The London School of Economics and Political Science

Funding Without Strings: an investigation into the impact of the introduction of Payment By Results into the National Health Service on aligning clinical and managerial incentives.

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Declaration

I certify that the thesis I have presented for examination for the MPhil/PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

I declare that my thesis consists of 81,897 words.

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Abstract

This research investigates whether the introduction of Payment By Results (PbR) into the National Health Service aligned clinical and managerial incentives and improved output, quality, quantity and productivity.

The methodology applies three data collection techniques; in-depth interviews; documentary data; and numerical data for each of four foundation trust (FT) case studies. The results indicate that the case studies had not produced consistent and sustained improvements in productivity and did not appear particularly engaged with productivity improvement, or cost control or in the relationship between these factors and tariff under PbR. Boards of directors did not appear to focus on productivity; and the use of service line reporting, to allow clinicians and managers of hospitals to drive productivity improvement, was not widely available at board or clinical level.

The results also demonstrated the dominance of Monitor, the FT regulator, in influencing the agenda of FT boards. It suggests that, without central direction and/or external pressure, FTs will not focus on productivity and quality issues.

The policy significance of these results are that (a) with the lack of alignment of clinical and managerial incentives, it is unlikely that FTs will be able to produce a sophisticated and targeted review of clinical care pathways to target productivity improvement at areas where there is real opportunity for efficiency improvement; and (b) if, as the research results suggest, NHS management, and the organisations they lead, respond more effectively to central direction and control then, as the NHS enters one of the most financially challenged periods of its history, alternative policy options to the development of quasi markets need to be considered. The research explores several of these options, including: the roll-back of the FT movement, management franchising, creating conditions for increased pressure on hospital performance, a more radical introduction of competition, and options for the use of social enterprises.

Contents

List of Tables

CHAPTER ONE

INTRODUCTION

'Beginning is easy - continuing is hard'

Japanese Proverb

1. RESEARCH AND CONTEXT

1.1 Current and historical context

In May 2010, world bond markets started to price the possibility of sovereign debt default into bond yields and the prospect of actual sovereign debt default of countries such as Greece, Spain and Ireland became a real possibility. There was also a strong indication from the credit rating agencies that UK sovereign debt would be subject to a rating downgrade inevitably leading to the government facing higher interest rates when issuing its gilts. The newly elected Liberal-Conservative coalition government in the UK therefore placed the control of public expenditure at the centre of government policy to settle international markets and demonstrate that the UK economy could control its ever increasing thirst for growth based upon the expansion of credit.

The British Government's resulting commitment to reduce public expenditure by an average of 25 per cent across all departments (excluding the NHS and International Development), with contingency plans for 40 per cent in some cases, left UK public sector services with the challenge of reviewing the spectrum of the services they provide, the input of resources they commit to providing them; the method of service delivery employed and the outputs that citizens can and should expect. In essence, the public sector is being forced to address the key ingredients of productivity, and will need significantly to improve productivity in its public services in the next few years or see large-scale service cuts.

In July 2009, Appleby, Crawford and Emmerson outlined three potential scenarios for the NHS based on three sets of real funding conditions that could apply 2010 onwards. The 'arctic' scenario projected real funding cuts of 2 percent per annum for 2010 to 13; 'cold' assumed zero real growth and 'tepid' assumed real growth of 2 per cent for the next three years. The report concluded that, in conditions of 'arctic' funding, average NHS

productivity improvement of 7.4 per cent per annum would be required if service output and quality were to be maintained; in the best scenario, 'tepid' average productivity growth of 3.4% per annum would be necessary. Given that the Office of National Statistics most recent estimates for NHS productivity between 1997 and 2007 indicates that NHS productivity actually fell 4.3 per cent during the period (an average fall of 0.4 per cent per year) (ONS, 2009) the delivery of productivity improvement in the NHS is now the most critical challenge facing the service.

The Liberal–Conservative coalition government which came to power in May 2010 initially indicated that real spending on the NHS would continue to rise in real terms in the post election period, therefore indicating a cold to tepid funding environment. Commentary by the chairman of the House of Commons Health Select Committee (Stephen Dorrell, former Conservative Secretary of State for Health) and others have indicated that the government should not ring fence health from potential real reductions in funding. Therefore many in the NHS expected a financial settlement in the October 2010 central government spending review to reflect 'cold' to 'arctic' funding conditions with the greater requirement for productivity improvement. In fact the outcome of the review resulted in a hcadline 0.1% real increase in funding, which, when adjusted for projected inflation in the 2011 financial year, resulted in a real increase of only £24 million on a budget of over £100bn (Appleby 2011). The need for productivity improvement was therefore intensified.

The NHS productivity dilemmas of today need to be placed in the context of the improved NHS funding heralded by the first New Labour Government of Tony Blair in 2000. In July 2000 Prime Minister Blair and his Secretary of State for Health, Alan Milburn, faced with growing political concern about Britain's international performance on various health outcomes (particularly cancer and coronary heart disease), launched the NHS Plan (the Plan). The relatively poor performance on health outcomes was exemplified by World Health Organisation data for deaths from heart disease for the three years to 1998 (WHO, 1998) that showed UK death rates per 100,000 population to be four times higher than in Japan, three times higher than France and materially higher than even the United States.

The Plan aimed to improve key health outcomes in England by 2008, promising several years of increased real funding of 7.5% per annum. The Government's objective was that Britain's reputation for spending relatively low amounts of its national income (as a

percentage of GDP) on health would be rectified with health spend in England targeted to rise to 9.4% of GDP by 2008 (DoH 2002).

Implicit in the Government's policy of increased spending on the NHS was the understanding that England's relatively poor performance on health outcomes for its citizens (when benchmarked against other European countries) was significantly affected by the amount of real resources invested in health care.

It is now a decade since the NHS Plan was introduced. Over recent years increasing concern has been expressed as to whether the gains from the increased resources (inputs) devoted to health care have produced sufficient benefit (increased outputs) to justify the investment.

Evidence on the achievement of NHS targets suggests that considerable improvement in NHS performance has been secured. For instance, in a large majority of hospital trusts the politically sensitive maximum waiting time of 4 hours for 98% of attendances in Accident and Emergency has been achieved and the concerted push to achieving the maximum wait of two weeks for urgent cancer referrals (to see a specialist consultant) has been met by a vast majority of hospitals. The NHS has also managed to bring waiting times from GP referral to hospital treatment down to a maximum of eighteen weeks for 90 per cent of all patients. This is a significant achievement for an NHS, which in 2000 was renowned for its long waiting times. (Indeed patients can now be faced with referral to treatment times that can be considered too short to obtain valid consent. For instance, the Liverpool Ocular Oncology Centre offers patients with an eye tumour rapid treatment. Surgical removal of the eye is usually performed within twenty four hours of initial assessment)

What is less clear is whether the Plan, and associated increased funding, has led to improvements in clinical outcomes. Survival rates published by Cancer Research UK suggest that deaths from common cancers, such as breast cancer, have continued to decline since the Plan was introduced; but it is not clear whether this was the result of the increasing resources devoted to healthcare and the NHS Plan or merely a continuation of a trend commenced in the 1970s as clinical interventions have improved.

There are probably three main areas of concern about the outputs from the Plan and subsequent target culture. First, there is anxiety as to whether the achievement of the centrally dictated output targets merely transferred resources from non-measured activities of the NHS (as suggested by Bevan and Hood, 2006) causing undesired and unexpected

consequences. An example of this would be the focus of resources on achieving access times as opposed to the quality of clinical outcomes.

The second concern is that if the amount of additional real resources which have been devoted to the acute health sector had been invested in wider public health policies such as health education in areas such as diet and lifestyle, then the total health gain for England might have been much greater. For instance, Nolte and McKee's (2004) review of literature on avoidable mortality suggests reductions in mortality from stroke may have been as a consequence of reduced risk factors (e.g. reduced salt intake) as opposed to being primarily driven by direct health care interventions.

Thirdly, and the area which this thesis addresses, there is the concern that although total outputs of the NHS have risen over the course of the Plan, the relative cost of the inputs to achieve those outputs have been disproportionately high. As mentioned earlier The Office of National Statistics (ONS, 2009) has indicated that national productivity over recent years has fallen and commentators have argued that this is in large part due to the relatively low increase in measured output compared to the large investment in NHS inputs.

Concerns about the Plan and its impact on NHS productivity had been identified as early as 2005; Bosanquet *et* al (2005) noted that parts of the Plan were costing significantly more than initial Department of Health (DoH) projections. For instance, the DoH estimated that the GMS contract alone would cost some £300 million more than initially projected. Bosanquet *et al's* estimate was that by 2010 (assuming NHS productivity remained at its 2005 levels) there would be a resource gap in the NHS of £6.8 billion. As Bosanquet *et al* noted *"We are left with the hope of a productivity miracle to bridge the gap"* (2005, p23).

McGuire and Van Reenen (2005, p 2) also commented: *"the stark fact is that NHS outputs have grown at a slower rate than NHS inputs implying a sharp decline in NHS productivity"*. The ONS's 2009 conclusions that NHS productivity had fallen between 1997 and 2007 would not therefore have come as a surprise to these commentators.

1.2 Background to the research

The idea for this research project originated while I was serving on the board of directors of an English teaching hospital in 2003. As described earlier, the Plan provided for large

increases in real funding for the NHS. In parallel with the implementation of the Plan, what were perceived to be tough performance targets for NHS hospitals to deliver were introduced into the NHS. My observations during that period suggested that the hospital had neither the data nor the inclination to understand the input costs of delivering the services and the efficiency of the process of treatment; nor did it have any effective measures for demonstrating the added value of the treatments the hospital provided to patients. It also appeared that management and clinicians did not have a common agenda. In particular, financial efficiency and the delivery of targets appeared to be the domain of managers while the focus of clinicians appeared to be around the expansion of services and, not surprisingly, the care of individual patients as distinct from the efficient allocation of resources between patients to maximise health benefit to the general population. This was born out by some systematic studies (Crilly and Le Grand 2004).

It was in this context that a new funding system for paying NHS hospitals for the treatments they delivered (Payment by Results) (PbR) was piloted in 2003 and introduced in the first wave of newly established foundation trusts (FTs) in 2004. PbR is modeled on systems implemented in other parts of Europe, including Ireland, Hungary and Portugal, and experiences from Australia and the United States. The basis of the system is that a patient condition is categorised in a particular cluster of treatments (according to average resource use) and is assigned a particular Health Resource Group (HRG). The provider of the treatment then receives a prospective payment for that particular treatment. For instance in 2008-9 a simple varicose vein procedure attracted a payment of £1074 and a primary hip replacement £5220.

In the period covered by this research PbR operated on the basis that the price paid in a relevant HRG was set at the average cost of the particular treatment for the NHS. If a provider incurred above average cost for the provision of that treatment then the provider would make a loss on that patient. Conversely, if the provider's average cost was below the average for the NHS then the provider would make a surplus. At the time of submission of this thesis (May 2012) Monitor, the new economic regulator, is reviewing the method of setting tariffs under PbR

A key objective of the introduction of PbR was to encourage providers who are above the average cost of delivery to reduce their costs over time in order to generate a financial

surplus which could then be invested in services. The intention was that, if high cost providers either exited the market or made efficiency savings, then over time the average cost of each HRG (ceteris paribus) would fall, thus improving NHS productivity.

For non-foundation trusts (non-FTs) PbR was implemented (in large part) on the 1st April 2006 and covered treatments for elective (inpatient and outpatient) care and emergency care. The first wave of FTs to be authorised in 2004 have been operating on PbR since their date of authorisation, as the opportunity to operate on the PbR payment system together with reductions in central control was one of the key incentives for adopting FT status. On average around 80% of FT and non-FT income is now covered by PbR.

The second key element of the reform agenda associated with the Plan, and closely linked to the introduction of PbR, was the creation of FTs. For the introduction of PbR to work as an effective incentive to drive productivity improvement it was felt that autonomous hospitals, outside the day-to-day control of the Secretary of State for Health (although still accountable to an independent regulator), needed to be established. This was in effect an extension of the autonomy that was given to NHS Trusts in 1990.

FTs were given the ability to retain cash surpluses generated under PbR and to hold them as reserves or invest them in the development of clinical services. This was a very attractive 'carrot" for many senior managers and hopefully clinicians. Also the initial drafts of the insolvency regime for FTs envisaged the possibility of FTs being subject to several elements of the insolvency regime for private companies (with some protection for the public assets transferred to FTs when they were first established). This lack of a state guarantee in cases of financial failure was to ensure that FTs performed in a financially robust manner. A combination of a payment system which allowed hospitals to generate surpluses and deficits, with the 'stick' of a modified private sector insolvency regime and the 'carrot' of the freedom to invest surpluses, was intended to create performance and productivity levers within the NHS.

1.3 The Research

In order for the introduction of PbR to be effective in promoting productivity, the 'carrot' and 'stick' will have to impact on both managers and clinicians. Clinicians will be key to

improving productivity. As guardians of the clinical pathway (i.e. the process of care by which hospitals treat patients) clinicians will need to promote greater efficiency by delivering more effective and efficient care for patients with fewer but better clinical interventions. Clinicians will need to be the willing leaders in the transformation of their clinical services.

So the central hypotheses of this research is that PbR will align clinical and managerial incentives leading to improved output, quality, quantity and productivity. The research uses productivity, documentary and interview data from four case study hospitals in England to explore this central hypothesis.

In order that mutuality of interest, or alignment of incentives, between clinicians and managers can occur clinicians would need to view the control of inputs, the application of efficient processes of care and the maximisation of outputs of the care process (both quantity and quality) as one of their key objectives. The introduction of PbR into the NHS (which establishes a price for a significant percentage of services provided by hospitals) has created an opportunity for clinicians to engage with managers in a conversation about the inputs, processes of care and outputs of treatment. PbR (when supported by an appropriate financial management system) allows clinicians and managers to understand the costs and income of delivering individual services and therefore whether a service is making a surplus or relying upon other parts of the hospital to cross subsidise its losses. As FTs need to be financially sustainable, services which generate a surplus (or at the very least do not make a loss) will be increasingly likely to attract more investment and be expanded. In some cases FTs could even cease to provide loss making services altogether if they are not core to the hospital and alternative provision is available either within the NHS or provided by the private or voluntary sectors. If PbR introduces, into the NHS, a greater ability to understand which services are financially sustainable, and which are not, then if we assume that clinicians who have worked in a speciality within a hospital for long periods of time, often twenty or thirty years, then it is reasonable to assume that they will wish to see that service continue and perhaps expand even if it is for reasons of self interest associated with continuation of employment (i.e. financial security) and personal status (i.e. not being associated with a failing service; or as Le Grand would categorise as knavish behaviour (Le Grand 2003). Therefore the ‘carrot ‘of expansion and the ‘stick’ of possible contraction of

services could produce an alignment of interest, and incentives between clinicians and managers therefore delivering increased output quality, quantity and productivity.

1.4 Structure

The thesis follows a conventional approach. Chapter Two sets out the research question and methodology including data collection and analysis and identifies the key strengths and weaknesses of the approach. Chapter Three develops an overview of the key literature on areas including, but not limited to, productivity, payment systems for hospitals and external influences on performance. The next three chapters set out the documentary, interview and productivity data respectively. The data are then analysed in Chapter Seven. Finally, Chapter Eight looks at what has been learnt from the research, including any general conclusions, and considers various policy implications. The final chapter also identifies the limitations of the research, both in terms of methodology and process, and identifies opportunities for further investigation.

CHAPTER TWO

RESEARCH QUESTIONS AND METHODOLOGY

"Where observation is concerned, chance favours only the prepared mind"

Louis Pasteur 1822-1895.

This chapter sets out in some detail the central and subsidiary research questions and the methodology employed in the research project.

2.1 RESEARCH QUESTION AND HYPOTHESES

2.1.1 Central Research Question

The central research question is to investigate whether the introduction of Payment By Results into the National Health Service has aligned clinical and managerial incentives and improved output, quality, quantity and productivity.

This central research question leads to three main subsidiary research questions set out below.

2.1.2 Subsidiary Research Questions

What is meant by NHS productivity and how has the NHS routinely measured outputs of NHS organisations?

What is meant by clinical and managerial incentives and historically has there been a difference between the two groups and their incentives?

If managers and clinicians have historically had different incentives has the introduction of PbR contributed to their alignment? If so, how?

We can reformulate these research questions as a specific set of hypotheses.

2.1.3 Hypotheses

- For NHS Foundation Trusts to survive they need to establish long term financial viability. This is dependent upon improved output quality, quantity and productivity; all of these are affected by the introduction of PbR.

- As clinicians wish to see their specialties, and their own clinical positions, maintained in their hospitals the introduction of PbR has acted as a performance lever on clinicians to operate their clinical services within clear financial constraints. More specifically, in order for clinicians to maintain their specialties and clinical positions, PbR acted as a lever on them to support the introduction of resource-efficient clinical pathways.

- The introduction of PbR has acted as a performance lever on NHS Foundation Trust Boards to improve their information systems, understand the costs of individual clinical services and focus management resource on high cost areas. This has led to production process improvements.

- There are two primary agents which control NHS Foundation Trusts, managers and consultants, and their primacy has been reinforced by the devolution of legal ownership of NHS Trust assets from the Department of Health to Foundation Trusts .

- PbR has provided an alignment of incentives for the two key agents in the NHS (managers and consultants) leading to improved productivity.

2.2 METHODOLOGY AND DATA

The intention of the research was to use research methods which allowed the triangulation of data, thus providing greater integrity to the conclusions of the research. The simple method of achieving triangulation would have been to ask the same question from different perspectives but using the same method. My objective was for the research to achieve "strong triangulation" by using multiple methods of research to address the same question. In particular, in-depth interview data with managers and consultants will be to some extent validated by documentary and numerical data.

2.2.1 Case Study Method

The research was based upon case studies because, as Yin comments, the case study is well suited to situations were the "*how and why questions are being asked about a contemporary set of events, over which the investigator has little or no control*" (Yin, 2003, p. 9). The research question is aimed at understanding how and why PbR affects management and consultant behaviour, and focuses, on organisational quantity and quality of output. The policy and process of PbR is not capable of being influenced by the researcher and the introduction of PbR is clearly a contemporary event as the NHS uses PbR as the main payment system for NHS commissioned activity.

Although some quantitative researchers argue against generalising from case study research, Yin (2003) argues that multiple case studies (as conducted in this research) allow theoretical generalisations (i.e. to generalise a theoretical position, as opposed to determining the frequency of occurrences) but not statistical generalisations. The research set out to provide a theoretical generalisation of the effect of PbR as a lever on managerial and clinical incentives in driving performance within the NHS.

The case study research design was developed so as to ensure construct, internal and external validity as well as reliability. Construct validity was supported by identifying the specific changes which were studied, relating them directly to the objectives of the study and ensuring that the indicators chosen to measure the changes actually reflected the change. For example, specific change might be board level focus on output and the measure

might be the focus by the board on such issues. Construct validity was reinforced by having multiple sources of evidence, such as documentary and interview data.

As the case studies were exploratory in nature a key issue was maintaining internal validity. Specifically, had all the possible factors of causation been identified and are inferences about causation correct (e.g not attributing increased board focus on output measures to the introduction of PbR when in actual fact the board focused more upon quality output measures because of concerns of board liability for corporate manslaughter). Internal validity concerns were addressed by directly considering rival explanations of possible inferences on causation in the analysis chapter.

As previously stated the research aimed to provide a degree of theoretical generalisability beyond the individual case studies. External validity of the research is therefore very important. If the research can show that any findings are replicated in a number of the separate case studies then direct replication of the findings makes it possible to make theoretical generalisations. This is identical in analysis to repeating experiments which come to the same conclusion and the common results then become generalisable.

The final issue in the case study design was to minimise the opportunity for bias in that design so that, should another researcher use the same case study and the same methodology, they would come to the same conclusion. The processes used in the case studies have been documented, effectively a case study protocol, to mitigate any concerns of design bias.

In order to increase reliability of the findings four cases were investigated (as opposed to focussing on one critical case study). The use of multiple case studies put greater pressure on both time and financial resources. An identical protocol was followed in each case and that replication of the findings in a case (as in the replication of an experiment) produced greater theoretical generalisability.

The use of multiple case studies was also a risk control measure. Should one of the case studies have been subject to interruption, for instance financial failure of one of the NHS Foundation Trusts leading to organisational amalgamation before the research was completed.

The selection of the NHS Foundation Trusts for inclusion as case studies (and selection of interviewees) was based upon qualitative sampling, not statistical sampling as in quantitative studies (i.e random sampling in order to make statistical generalisations). Case study (and interviewee selection) was based upon purposive sampling (Hansen 2006 p.52) which considered carefully the number and range of situations and views of participants in the study and intentionally included an outlier which, in a conventional quantitative analysis, would be excluded.

As noted above, case studies can be representative and generalisable to the extent we are trying to establish theories. It is sometimes helpful to either replicate a case study to reinforce the previous findings or find a contrasting case study to see if the theoretical findings in an initial case can be extended to a contrasting environment. For instance, could management and consultant behaviour in a financially viable NHS Trust be identical or reinforced in a financially challenged environment? For this reason one of the case studies selected was one that had faced financial difficulties and was therefore a contrasting study compared to the other three financially robust studies.

2.2.2 Main Case Studies and Selection

Three criteria were used to identify the four NHS Foundation Trusts (FTs) to be used in the study, namely legal status, strategic health authority and financial condition.

The structural changes in the NHS, since the introduction of the legal status of FTs, has created two forms of acute trust delivering services to patients within the NHS: FTs answerable to their members, governors and regulators; and traditional NHS Trusts ultimately accountable to the Department of Health. To ensure that any variation in the research findings were not affected by the legal status of a case study, all the case studies were of FTs .

FTs, as opposed to NHS Trusts, were selected as, at the time the research was being initiated, the growth of the FT sector was significant with the government aiming to have all hospitals operating as FTs within a few years. Although this process was not completed by the Labour Governments of Blair and Brown, this conversion remains the intention of the present Coalition Government (DoH 2010).

The NHS has been subject to very different performance cultures within the various regions of England. This is best exemplified by the large collective deficits recorded by hospitals and primary care trusts in the former strategic health authority (StHA) of Hampshire and the Isle of Wight compared with modest surpluses in Dorset and Somerset. The selection of FTs as case studies therefore removed this second variable from the analysis as FTs are not subject to the control of individual StHAs but instead are regulated by a common regulator, Monitor, which applies a legal regulatory framework and therefore consistently applied performance rules (Monitor 2011a).

As indicated earlier the final factor in case study selection was the issue of long term financial stability of the relevant FT. The financial stability of the FT was chosen as a factor in case study selection as the researcher considered that financial sustainability could be a catalyst for general management, and clinicians, to focus on the costs and income of an organisation and therefore lead to greater engagement with PbR. At the time of the case study selection Monitor (as the lead regulator on financial matters for FTs) operated a financial risk rating (FRR) ranging from four (the strongest rating) to one (the weakest rating with potential rights for Monitor to intervene). Three of the four case studies (below) had good FRR ratings of three or above and therefore underlying financial condition should not be a variable impacting upon the results in those three case studies.

The main case studies were:

AA NHS Foundation Trust (FRR4)

This was an established FT operating in the South East of England. Although not one of the first FTs to be authorised by Monitor, it had a track record of achievement as an FT. The management team was experienced with leadership from a long serving chief executive and had a good record of delivering on national targets. The hospital was based in an affluent urban context with several other NHS and private sector providers within relatively close proximity. It had a strong record on financial performanc*e.*

CC NHS Foundation Trust (FRR 4)

This FT was authorised by Monitor in one of the earlier waves of applications. The management team was again experienced, with leadership from a long serving chief executive. The hospital had a solid record of delivering on national targets but had faced

some financial difficulty a few years previously. These issues were effectively resolved and at the time of the research the trust had a robust financial record. The hospital was based in the South of England and in a rural environment with no alternative NHS, or private sector provider, within a reasonable travel distance.

DD NHS Foundation Trust (FRR 3)

This trust was also authorised by Monitor in one of the earlier waves of applications. The management team was again experienced with leadership from a long serving chief executive. The hospital had a solid record of delivering on national targets and had a good financial performance. Based in a low density urban environment with good communications the local community was served by several NHS hospitals of various sizes and private providers were also operating within the locality.

2.2.3 Outlier Case Study

For the reasons identified in the case study method section (i.e. can the case study findings be extended to a contrasting environment) one case study was chosen as an intentional outlier in that it had been rated by Monitor as subject to higher financial risk than the main cluster of FT's. It was hoped by including this outlier in the study that any impact of differences in underlying financial condition would be highlighted.

The outlier case study BB NHS Foundation Trust had an FRR2. It was again based in the South of England. It was an early wave FT applicant based in an urban environment but serving a relatively poor population. The city where it was located was served by several other hospitals (private and public) but by the nature of its population and service portfolio the choice of provider was effectively limited. Leadership was provided by a long serving chief executive and experienced senior management team.

2.2.4 Interview Method

Key research technique texts such as Bechhofer and Paterson (2000) argue that, because most researchers believe they can interview, other methods of investigation should be first explored to ensure that the interview is the most appropriate research method to be used.

As the aim of this research was to obtain strong triangulation in the research results, reliance purely on numeric and documentary data was not appropriate and therefore an additional method of data collection was required.

The aim of the research was not only to identify what had happened, but how and why it had happened and the research was therefore explanatory in nature. The research question was also contemporary as most of the key players in delivery of the Plan were still either in post or accessible. For these reasons the use of case studies, based upon a small number of quality interviews, was considered an appropriate method of data collection (Yin 2003).

The data acquired from the interviews was intended to produce both descriptive information concerning decision making on such issues as rationalisation of health care production processes, and also provide explanations as to why, or why not, these changes occurred. The interviews also allowed further investigation of the issues which emerged from the document review including, in particular, explanations of causation of behaviour trends established in the documents.

There were no simple academic criteria that could be applied for selecting the interview respondents but the criteria the research employed will be outlined and justified. Bauer and Gaskell (2000) note that an individual researcher can probably cope with 15-25 individual interviews. As the research included two other data sets the study aimed to interview 4-5 people in each case study FT, a maximum of 16-20 interviews. Eighteen interviews were finally completed.

The basic criteria the study used to choose respondents was to identify individuals who would be information-rich. As Bauer and Gaskell note "*The real purpose of qualitative research is not counting opinions or people but rather exploring the range of opinions*" (Bauer and Gaskell 2000 p.41). For this reason the research attempted to identify both key supporters and opponents of changes within each of the case studies for interview.

There are four main types of interview: structured, semi-structured, unstructured and informal interviews. These can be individual or group interviews and the method of conducting the interview can be in person, by telephone, video link or web based.

The first interviews were all individual, and face to face, in order to fully engage the participants in the project and develop personal relationships so as to maximise the

willingness of the respondents to disclose issues around incentives. Had it been necessary to ask follow-up questions, the intention was to employ e-mail and telephone. Video conferencing was viewed as unrealistic considering the limited access to this within FTs at the time. In the event, the need for follow-up interviews was not apparent and access to such senior individuals, for a second time, would have been difficult to achieve.

Semi-structured/unstructured interviews (unlike a structured interview which has defined questions with a narrow range of possible responses) allowed in-depth understanding to be obtained by the researcher which in the case of identifying consultant and manager incentives was imperative. For this reason the structured interview was discounted because of its lack of flexibility and depth.

The need for the interviews to be efficient, yet flexible, led to the choice of the semi-structured interview and the discounting of unstructured interviews as insufficiently focussed. This enabled the development of an interview guide so that all interviews could cover the core areas of investigation yet allow the interviewer to develop the questioning as the interview progressed and so develop issues which emerged during the meeting. The interview guide which was developed ensured that the questions were open-ended, neutral, sensitive and clear (Patton 2002, as stated in Holloway 2005 p45).

As Hansen (2006) suggests, the interview guide and process was trialled on a limited number of participants before the main interviewing commenced, in order to remove weaknesses in the style, type or breadth of questions/topics covered. The interview guide and process was trialed in two ways. It was first tested with a non-NHS specialist but with wide management experience for weaknesses in question meaning and interpretation. The guide was adjusted and then tested on a senior executive director of finance, with particular experience of the subject matter of the thesis, as a representative of the target group. This led to a final modification of the interview guide which is set out in Appendix 1.

With regard to conducting group or individual interviews the study was structured around individual meetings. Although a broader number of respondents could have been captured by the use of the group interviews, the intention was to obtain in depth analysis on incentives (and depth of understanding) and such disclosure would not have been enhanced by group interviews. In addition, many of the respondents were high value senior managers

and consultants with time critical schedules and therefore the need to schedule the interviews around individual diaries made group interviews impracticable.

As indicated above the interviews focused upon high level management and senior consultants within each FT. With the capacity to interview only four to five respondents in each FT interviewee selection was critical. For this reason the key executive member of the management team to be interviewed was the director of finance as the holder of that position was conversant with the detail of PbR and was responsible (in conjunction with other operational managers) for the alignment of average costs of the organisation to be broadly in line with the relevant HRGs under PbR. The finance director, often with the director of operations, would also be the person responsible for the implementation of any cost re-alignment and therefore was likely to be a strong voice for improvement in care processes within the FT.

In each FT two senior clinicians were also identified for interview. Most FTs had a clinician who was supportive of system reform and who had driven change in clinical processes and this person was the first choice to interview. In each case study the Medical Director was successfully recruited to the project to fulfil this role. This proponent of change was balanced by a senior consultant who was less supportive of PbR and system reform to provide a counter perspective.

The final target for interview was the manager of the orthopaedics division of the FT. This clinical area has a tendency to be subject to heavy competition from the private sector, has strong and independently minded clinical leaders and can be the focus point for many of the initial PbR reforms. The divisional manager of orthopaedics was therefore considered to be in a strong position to assess the causation (or limitations) of output, quality and productivity improvements and holds the politically uncomfortable position of high levels of contact with consultants yet still being responsible to senior management for systems change. This creates potentially an ideal position for obtaining an insight into consultant-management incentive alignment.

In addition to the sixteen people the research intended to have access to, two of the case study chief executives also volunteered to be interviewed which provided an additional level of insight and further supported the richness of the interview data.

As highlighted above the number of interviewees was limited by constraints of both access to the case studies and resource available to the researcher. If case study access and researcher resources had not been a limiting factor the researcher would have made several key changes. Firstly, interviews with non-executive members of the board of directors would have been conducted. This would have given a non-NHS view around the research question that might have provided challenge to professional NHS views presented. Secondly, a larger number of operational managers and members of the consultant body would have been interviewed to get a richer understanding of the objectives and incentives of clinicians and managers. Thirdly, to improve generalisability, interviewees would have been identified from specialties such as medicine where co-morbidity and complexity often makes operating under PbR much more complex than within orthopaedics.

2.2.5 Documentary Data

The objective of the review of the board documentation was to find a high level relationship between the introduction of PbR and a drive by the organisation to better understand the cost structure of the production units of the FT, and the processes of the organisation (such as updating and standardisation of clinical pathways for specific treatments).

The advantages of using documentary data was that due to the Freedom of Information Act (FoI) large amounts of this data could be accessed as of legal right, much of it being accessible via electronic means. In the event FoI requests were not required as all four FT case studies continued to provide access to non –commercially sensitive board papers (commonly referred to as Part 1 papers) via their publicly accessible hospital websites. At the time the research commenced, access to the case studies and their data had been considered a significant threat to the viability of the project. This risk did not materialise.

The document review required a coherent, transparent, reliable and valid coding system (Bauer and Gaskell 2000). It was intended that a computer assisted coding package be used but as Bauer points out “computers, useful as they are, are unlikely to replace the human coder” (Bauer and Gaskell 2000). The researcher considered the use of NVIVO 7 and ATLAS.ti 5 but, after trialling both packages and comparing them to the results of a more labour intensive windows document search based approach, the windows search engine was

adopted. Although much more labour intensive, and possibly subject to greater human error when searching the documents, the researcher found that the technique was more effective in identifying the context in which key words and phrases were being used and therefore increased the quality of the results, particularly from an analysis/interpretation perspective.

The material reviewed focussed on the documents which provided a strategic overview of the FTs focus and recorded high level organisational performance issues. These were the board minutes of the FT case studies, as effective boards should focus on high level performance issues and activity/quality and outcomes data (Machell, Gough and Steward 2009).

The researcher also considered reviewing board sub-committee minutes where delegated authority had been given by the board to a committee to assess hospital performance/productivity and quality issues. Although these documents might have provided more detailed information, effective boards would have required the key issues raised in those committees to be formally reported to the board (Cadbury 2002, p. 99) and therefore be recorded within the board's minutes.

In addition, access to minutes of board sub-committees are not as commonly available to the public as board minutes (although the content may technically be available by use of the provisions of FoI). On balance the researcher concluded that the time burden of securing access to the documents and then conducting systematic searches was not justified as the key learning from the material would have been highly likely to have been recorded in the main board minutes.

2.2.6 Output data

In addition to the collection of documentary and interview data, the research project also identified whether each of the case studies had shown evidence of improving productivity in the period leading up to, and during, the collection of documentary and interview data.

The researcher considered two approaches to the collection of this data. Option one was to collect primary activity and cost data for each of the four case studies, either on a hospital-wide basis or by reviewing several distinct data sets focussing upon some key specialties,

for example orthopaedics. The alternative approach was to use a data set, or combination of data sets, which had been collected nationally using a standardised methodology and the project could therefore avoid key weaknesses associated with primary data collection.

Three key factors influenced the approach taken. Firstly, the collection of primary cost and activity data, when combined with the collection and analysis of the documentary and interview data previously outlined, would have made the research project too substantial for a PhD given the limitations of time and resource.

Secondly, the case study FTs had allowed access to the researcher on the basis that the research project would require limited involvement from staff and senior management. Initial soundings of the case studies indicated that the requirement for data access, and greater hospital staff engagement in the research, would have materially prejudiced access to the FTs.

Finally, at the time that the research was being conducted, FTs were becoming increasingly reluctant to allow outside parties access to data which might be considered commercially sensitive, one of the consequences of creating a quasi-market in public services. Up to date cost data relating to specific specialties would have been considered commercially sensitive and therefore presented a significant risk with regard to the potential withdrawal of access rights to the four case studies.

As a consequence of the above factors the researcher considered that the identification of proxies for productivity for each of the case studies, using national data sets, presented the most efficient method of identifying whether each of the case studies had shown signs of productivity improvement over a set period.

The research project therefore used two data sets as an indication of the levels of productivity in each of the case studies. Firstly, the relative cost index (RCI) of each of the FTs in the study for the period 2005-6 to 2007-8 were analysed. The RCI is calculated by the DoH by collecting cost data from each provider, the average cost of providing services in England is then calculated with the average being denoted as an index number of 100. Those providers with an RCI of over 100 are therefore relatively expensive service providers with those below 100 being relatively cheap. This data set was particularly useful as it identified the FTs relative cost position against other NHS hospitals in England.

Therefore improvement in productivity above that of other hospitals would be indicated by a falling RCI for that FT.

The second data set used in the study was produced by the DoH's Institute of Innovation & Improvement which benchmarked NHS Trusts against several key productivity metrics based upon the Ten High Impact Changes for productivity which the Institute highlighted in 2004 (Modernisation Agency 2004). The research used four of the data sets available: length of stay (LoS), day case rate, pre-operative bed days and emergency re-admissions within 14 days.

The first three indicators were selected because they are closely related to the process of care. As improvements in productivity within a hospital are only likely to result from addressing the core business of the unit, the process of care, these indicators were considered a good proxy for process improvement and therefore productivity. The fourth indicator, emergency re-admissions within 14 days, was chosen in order to give a broad indicator as to what might have happened to the quality of output in the same period. Increases in unintended re-admissions after treatment were considered a good proxy measure for declining quality.

More detail on the data sets and their limitations are set out in Chapter Six. The next chapter introduces some of the key literature which informed the construction of the research.

2.2.7 Timing

The timing of the research was driven by three main factors. Firstly, FTs had been chosen for the research as they were being identified as the high performing hospitals within the system but the first FT was not authorised until 2004. It was therefore considered necessary to allow the FT movement to become established before research could effectively be conducted.

Secondly, access to the case studies needed to be secured. Approaches were made in the spring of 2007 and access secured during August 2007. It was therefore important to proceed as quickly as possible.

Thirdly, the researcher was studying part time and therefore the interviews were conducted at a time he could take unpaid leave. The period September to March 2007-8 met this requirement.

2.3 RESEARCH ETHICS

The research was based upon three data sets; productivity data, documentary data and interview data involving human participants.

The productivity and documentary data was all in the public domain. The productivity data was accessed through the publicly available Department of Health information portal and related to organisations rather than individuals. The documentary data was derived from publicly available board minutes, accessed through information portals of the hospitals identified as the case study sites. In both cases these data sets did not provide any ethical issues for the research.

The third data set was derived from one to one interviews with very senior NHS clinicians and managers within the NHS conducted by the researcher. Due to the seniority, status and experience of the individuals interviewed all participants had the legal capacity to give consent and were not in any way vulnerable, in terms of giving meaningful consent, to either participation in the interviews or the use of the information generated from those interviews. All participants in the interview process gave their consent to be interviewed and for the information to be used in this research project on an anonymised basis. In line with research ethics the research has been conducted on the basis of those consents.

CHAPTER THREE

LITERATURE REVIEW

'To be conscious that you are ignorant

is a great step to knowledge'

Benjamin Disraeli

This chapter considers the five main areas of literature which provided the basis for this research project. It is not intended to be an exhaustive summary of the literature, but aims to identify and to evaluate some key material.

3.1 Meaning and measurement of productivity

The measurement of productivity has become the focus of much debate over recent years as the need to show that NHS productivity has risen, with the implementation of the Plan, has become politically important.

In May 2001 the Office of National Statistics (ONS) embarked on a project to measure productivity in public services. The objective was to resolve the problem that, in the marketed sector of the economy, better quality products and services are accommodated in productivity measures "by adjusting downwards the price indices used to deflate the money value of the output" (Pritchard 2001 p67). The non-marketed sector of the economy (including health services produced by government free at the point of consumption) have historically been analysed on the basis that inputs to the production process are a proxy for output therefore ignoring any concept of added value. It had also been assumed that productivity in the non-marketed sector was constant over time.

In October 2004 the ONS report concluded that using the definition of productivity as

> "*the ratio of NHS outputs to NHS inputs, after separating out the impact of pay and price increases*"

NHS productivity had fallen during the period 1995 -2003 with output growing by 28 per cent

and NHS inputs by between 32 and 39 per cent for the same period (ONS 2004 p.40).

The ONS report concluded that over the period 1995-2003 the average annual change in NHS productivity had either shown no change or had declined by as much as 1% annually. The report was explicit in its conclusion that this took no account of improvements in quality. Finally, the ONS report noted that the bundle of services carried out by the NHS changes over time and if the bundle of services analysed no longer reflects the current focus of NHS activity (which in a dynamic clinical environment continuously changes) then the reliability of the bundle for a proxy of NHS activity will not be accurate.

It should be noted that the aging NHS information systems do not often capture changes in output as a consequence of process change; for example, the shift of procedures from inpatient to outpatient settings (such as hernia and eye surgery). As outpatient procedures do not consume resources associated with bed occupancy (e.g overnight nursing cover, feeding and hotel services), ceteris paribus, this process change can represent a significant productivity variation. This limits the accuracy of the ONS analysis.

McGuire and Van Reenen argued that the complication with measuring the output of the service sector in general (and the NHS in particular) is the "multidimensional nature of output and the importance of quality variation within the sector"(McGuire and Van Reenen 2003 p1). They therefore agree with the ONS as to the importance of the content of the service bundle for analytical purposes.

The express limitations set out in the ONS report must therefore raise significant questions about the usefulness of the report in determining whether NHS productivity has changed or not. As the Plan prioritised improvements in quality as an objective then the failure of the report to take account of quality change is a material limitation. A key question must be to what extent the achievement of access targets, such as accident and emergency department waits, contribute to quality and whether improved health outcomes (such as falls in mortality for circulatory disease and strokes) can be attributed to health care quality improvements.

The exclusion of variations in quality from the ONS's assessment of productivity has been criticised by many commentators including Dan Berwick *(2005)*. Berwick correctly notes that NHS productivity should refer the ratio of inputs (in which he includes labour capital and supplies) to that of outputs. Berwick clearly argues that by using activity as a proxy for productivity we are using "misleading shortcuts" (Berwick 2005 p.976) and this is not

acceptable despite the difficulty in assessing productivity in a more precise manner.

The weakness of the ONS report is also highlighted by Berwick in terms of the significance which is given to different forms of activity when assessing output. In particular, he comments that one inpatient treatment is weighted 14 times heavier than an outpatient visit despite producing identical clinical outputs.

At a time when the NHS has a strategic objective of transferring many of its activities from an inpatient to an outpatient setting Berwick's criticism of the methodology for weighting activity is clearly important, as is his criticism of non-use of real outcome measurement.

In parallel to the ONS work Professor A.B Atkinson (with support from the ONS and other government bodies) was asked to address the issue of how to measure non-marketed output (Atkinson 2005). Many of the key recommendations of the final report were focussed upon methodological issues for the compilation of national accounts (and therefore beyond the scope of this review) but some recommendations are directly relevant to the issue of how we measure NHS productivity change.

Atkinson challenges the historical method of measuring non-marketed output as not only unacceptable on public accountability grounds (i.e. because productivity was assumed to be constant in public services politicians were not held accountable for poor public sector efficiency) but also on the basis that the accuracy of input data is in question. The assumption that input is equal to output is to carry over inaccuracy in input measures into final output. For example, Atkinson notes the lack of measures for capital service inputs which are a material element of NHS inputs.

Atkinson's recommendations included a clear need to build in quality change into output growth, a move to direct output measurement and a review of appropriate input deflators (in particular pay and price deflators should be sufficiently separated to take account of changes in the balance of inputs over time).

With regard to quality Atkinson argues that it should be measured on a case by case basis but that three criteria: differentiation of service (if applicable), success of activity or contribution to attributable outcome (if contribution can be "directly and confidently attributed to the service") should be the basis of the measure. Specific recommendations include collecting new information and attributing values to changes in health outcomes and treatment patterns,

such as quality standards in general practice, speed of access to elective treatment, accident and emergency waiting times, ambulance emergency response times and patient experience (through the national patient survey programme).

Atkinson's conclusion that quality is fundamental to assessing non-marketed output (and therefore productivity) is intuitively appealing. It is interesting to note that many of his proposed measures (such as access times and patient experience) relate directly to those targets set in the government's national performance framework for the NHS. Critics could see this as a method for inflating productivity growth by means which have added no tangible value to the nation's health, but may have given the electorate a belief that the NHS is improving.

Commentators, such as Bevan and Hood (2006), note that some of the above performance measures have had unexpected negative effects on the NHS (including reductions in quality) as the targets have produced undesired producer behaviour.

They have argued that gaming has occurred in response to performance targets. They cite underperformance in areas which have not been subject to the performance framework, for instance the closure of ambulance units in rural areas (thus reducing service quality) and the opening of additional units in already well provided urban areas to achieve targets for category A calls. They also note that Bristol has achieved its ophthalmology waiting times by cancelling/delaying follow-up outpatient appointments thus causing at least 25 patients to unnecessarily lose their vision over a two year period (Bevan and Hood 2006).

Any measure of quality, for productivity purposes, must capture changes in quality that occur including the unexpected effects of the performance framework itself. As noted, a key element of NHS output which Atkinson wished to capture is success of activity/ contribution to outcome. If we first consider success of activity much (yet not all) of the NHS's outcome data is focussed on mortality rates. Thus for cancer, and other conditions with a high incidence of mortality, such data is routinely collected and could be incorporated into quality output measures.

Leatherman and Sutherland have produced some of the leading work in this area and have analysed data on outcome rates over time. For example, they show that between 1993-2003 mortality rates from stroke for people over 75 years declined by approximately a third in England. The limitation of the data is that it does not establish that the fall in mortality is

"directly and confidently attributed to the service" (Leatherman and Sutherland 2006). Due to the lack of attribution the outcome data (in its present form) would not be sufficient as evidence of improved health resulting from health care.

As a direct result of the recommendations in the Atkinson Review the ONS now makes an attempt to adjust NHS output figures to take account of changes in quality. Healthcare quality adjustments fall into two broad categories: service responsiveness to user needs (represented by the annual National Patient Survey (which includes patient views on information and communication, choice and safety)); and service success in delivering intended outcomes (this considers short term survival, health gain following treatment in hospital and changes in waiting times. On average the quality adjustment to total output has added 0.5% annually between 2001-9 inclusive (ONS 2011 p12).

The most recent step forward which will allow the ONS to adjust output to more accurately reflect the quality of the service delivered is the development of the patient reported outcome measures (PROMs) for several surgical interventions including hip and knee replacement. Devlin and Appleby note that although the ONS has attempted to make adjustments to national output data to reflect changes in quality to date there has been 'a lack of any data directly bearing on this' (Devlin and Appleby 2001 p. 59). Devlin and Appleby's view is that when PROMs are extended over a wider range of interventions then this will be an effective data base for more accurately adjusting output measures to reflect quality. This view is supported by the ONS (ONS 2011 p .23).

The overwhelming need to be able to measure the outcomes of the NHS has resulted in a key development over recent years. In the absence of robust outcome measures, the NHS has increasingly relied upon care process measures as a proxy for quality measurement. The same approach has been used by the NHS as quality indicators for regulatory compliance (please see section 3.5 below).

McGlynn noted that the UK had the "most extensive use of process quality measures to date" (McGlynn 2009, p17); in 2004 the UK government invested an additional £1 billion of public funds in rewarding general practitioner practices in England for achieving various care quality process measures set out in the Department of Health's Quality and Outcomes Framework (2004). This framework allocated points to general practioner practices which achieved various process measures.

In the acute setting, the introduction of higher levels of payment for hospitals achieving prescribed processes of care, which are considered to provide better outcomes, are reflected in the creation of best practice tariffs (BPT's) under PbR. For instance, the BPT for stroke aims to reduce the ' significant unexplained variation in practice' by setting standards for urgent brain imaging and reporting (DoH 2010 p. 50).

The impact of the above literature for this research is that the productivity data for the four case studies in Chapter Six will not accurately reflect changes in the quality of output occurring during the period of this research. As a consequence the productivity metrics, and RCI data presented, will either understate or overstate changes in productivity. This is a general limitation faced by research in this field and is noted within the Chapter Six.

3.2 NHS Productivity

As noted in 3.1 above the ONS concluded that NHS productivity had fallen during the period 1995 -2003 with output growing by 28 per cent and NHS inputs by between 32 and 39 per cent for the same period (ONS 2004). This picture of declining, or at best static, productivity is confirmed by various later studies looking at different parts of the NHS.

The National Audit Office's (NAO) review of the contract for general practice services in England concluded that a key element of the DoH's business case to the Treasury for the new GP contract (the delivery of a year-on-year increase in productivity of 1.5%) was not delivered and in fact ONS adjusted GP services figures for 2005-6 show an actual year-on-year productivity decline of 2.5% (NAO 2008 p. 9).

The hospital sector has also demonstrated a similar record on productivity in the last decade. The NAO's 2010 report on hospital productivity notes that ONS quality adjusted data for hospital productivity shows a decline of 1.4% per year compared to an NHS overall decline of over 0.2% (NAO 2010 p. 6).

The Centre for Health Economics (Street and Ward 2009 p.iii) as noted by Appleby and Ham (2010 p.7) conclude that within these general conclusions on NHS productivity certain years have shown some improvement, in particular from 2004-5 to 2007-8, as a greater number of patients have been seen, subjected to shorter waiting times and treated to a higher standard; outputs have risen at a higher rate than inputs.

The most recent report on NHS productivity for 2009 (ONS 2011) indicates provisional figures for productivity growth of 0.7% in 2009. If one takes into account that estimates for increases in quality of output added 1.1% to the 2009 output figure then, given the ONS's concerns about the reliability of the quality adjustments the initial estimates of productivity, improvement in 2009 should be treated with caution.

The NAO concluded that the poor productivity record of the NHS hospital sector was a consequence of NHS managers not focusing sufficiently on NHS productivity but instead on 'the delivery of national performance targets and delivering financial balance. The national focus on quality of care has meant that clinical staff have not been performance managed with regard to the cost or efficiency of their activities'(NAO 2010 p.8). An alternative view is presented by Smith in his prescription for a world class NHS, he notes that most of the extra expenditure up to 2006-7 'has been eaten up by administration and staffing costs' (Smith 2007 p. 43). He is particularly critical of the national pay agreements for consultants and nursing staff. Smith's view is partly supported by the Kings Fund's analysis which attributes £1.7 billion of the £4.5 billion increase in hospital and community health funding in 2006-7 directly to pay pressures (approximately forty per cent) (Kings Fund 2006 p.2-3).

For the purposes of this research the evidence for NHS productivity for the 2000-2010 suggests that overall NHS productivity has fallen by 0.2 percent per year (and in the hospital sector by 1.4 percent) (NAO 2010) but within that overall position between 2004-2008 the NHS has shown some productivity gains (Appleby and Ham 2010). As the data collection occurred during the period that NHS productivity showed some improvement then it is possible that the productivity metrics and RCI data in Chapter Six may demonstrate some productivity improvement.

3.3 Competition and Choice

Burgess, Propper and Wilson (2005) reviewed the main economic research literature attempting to identify what evidence had been produced as to whether choice (i.e service provision by several providers in competition with one another) leads to improved outcomes in education and health care.

Burgess *et al* (2005) note that choice has been attractive to policy makers because (by applying standard economic analysis of the private firm) the expectation is that by competing

for consumers, private entities improve in efficiency; both in cost and quality. Implicit therefore is that the discipline of choice can provide similar gains in the public sector.

The authors conclude that, for the health sector, choice will certainly create competition between hospitals but this will cause consolidation within the provider market with such mergers reducing the potential benefits of competition. Hospitals are likely to specialise in some treatments (and discontinue others) effectively reducing competition in those specialities and that there will be increased variation in the treatment received by individual patients. They suggest the benefits will include lower hospital costs (this is supported by the international evidence in 8.4) and improved quality as providers are forced to differentiate their health products by quality criteria as opposed to price. Burgess *et al* suggest that, in light of the potential for market consolidation by hospital mergers, the DoH will require a pro-competition policy. Competition provides a challenge for the NHS in that historically the achievement of stability has been the modus operandi of the system.

Le Grand (1999) notes that the NHS's introduction of an internal market in the 1990's had minimal impact upon the health system because central government retained large amounts of control and the motivations of managerial and professional groups within the system had not been fully understood. Or as Le Grand commented *" the motivations for change were relatively weak, especially when compared to the pressures for stability from outside"* (Le Grand 1999, p33). Le Grand's argument is that for the internal market to be effective, the patient's agent (the GP in this case) requires incentives to respond to market signals and there needs to be a lack of constraint on the agent to respond. He argues the degree of control exercised by health authorities, in order to avoid provider instability, was significant and this limited the ability and willingness of GPs to respond to market signals and change commissioning behaviour.

Burgess *et al* (2005) identified two key problems with increased competition. Firstly, that if the price for a procedure is too low then quality may fall as providers either exit from that product line (the most expensive may exit but they may be providing the higher quality product) and skimping and dumping of patients may occur. This involves avoiding the treatment of the more complex patient within each HRG while attracting the less expensive by offering higher perceived consumer quality. Quality may of course constitute superior hotel type facilities (from the patient's perspective) as opposed to any clinical superiority.

Will choice actually be exercised? Burgess *et al* also note that in the DoH's choice pilot schemes (urban centres Manchester and London) patient choice was facilitated by good administrative and information support to patients along with financial support to cover travel. It is highly unlikely that the information, technical and financial support will be available on a full system roll-out.

Le Grand (1999) provides some indication of what can be expected in a more quasi market environment in his review of the NHS internal market ("IM") in the 1990's. Although, as mentioned earlier, he thinks the impact of the IM was minimal (because of government control and behaviour of clinicians and managers) he does identify some key themes. He tentatively argues that a very crude measure of productive efficiency (pre and post the internal market) indicates that post reform this improved by about a third from *1.5%* to 2% (Le Grand 1999 p.30). He also argues GPs who were fund holders (i.e. controlled delegated budgets) generally obtained better and faster responses from the acute providers on behalf of their patients. On this basis we might therefore expect competition (if exercised) to promote efficiency and quality.

Criticism of the IM often focuses upon transaction costs associated with managing provider contracts. Le Grand acknowledges administrative costs of the NHS increased from 8-11% between 1991-2 to 1995-6 (Le Grand 1999 p30) but he argues the output and other improvements during the period outweigh this cost.

Both Burgess and Le Grand support the concept of choice and competition and suggest that improvements in efficiency and quality can be produced in such an environment. The key concerns are that Burgess *et al* argue that the market may well consolidate (especially for providers) thus sustaining what are often local provider monopolies. Le Grand raises the prospect that the inability of the government to cease controlling the NHS, coupled with not understanding the motivations of key players in the quasi market, may limit the effect of system reform. In either situation the potential gain from the current government's reforms could be muted. Or as Klein concluded on the IM "*the outcome was less catastrophic than its opponents feared and less radical than its proponents hoped*" (Klein 2001 p.115).

Other concerns expressed by some critics of competition and choice in the health sector, that such policies lead to service inequality, was partially addressed by Cooper, McGuire, Jones and Le Grand (2009) in their review of reductions in waiting times access across socio-

economic groups in England. Although their research could not attribute the reduction of waiting times between 2005-2007 to the introduction of patient choice and competition into the NHS, as several policy variables (such as increased funding and waiting time targets) were acting concurrently, they did conclude that the introduction of patient choice and competition had not led to the inequitable distribution of access to treatment, in terms of waiting time, across socio-economic groups. If anything, it appeared that during the whole data period, 1997-2007, variation in access times to treatment by socio-economic group had actually declined.

Dixon and Le Grand (2006) also argue that even in the absence of choice and competition in the NHS, inequities in the demand and supply of NHS services by socio-economic group already exist. For example, variation in knowledge, costs of access (e.g. transport) and capabilities of service users impact on service access. Dixon and Le Grand argue that choice and competition policies, if designed well, can actually reduce inequity by providing users with agents (or key workers) to support the patient in exercising their choices effectively.

The concern that competition can have the effect of reducing quality in service provision was addressed by Gaynor, Moreno-Serra and Propper (2010) in their review of 13 million NHS admissions. They concluded that death rates, and lengths of stay, were lower in areas of the country which had multiple providers suggesting that competition can lead to higher quality. The authors noted that as commissioners could only procure services on the basis of quality (price being set under the PbR payment system) the potential negative consequences of competition leading to commissioning by price rather than quality was not evident. Their conclusion was that the structure of the pricing system in an internal market was therefore a factor in ensuring competition promoted quality.

In addition, recent research by Bloom, Propper, Seiler and Van Reenen (Revised 2011) applied a new management capability survey tool to English hospitals and they concluded that the presence of a competing hospital in a district is associated with a significant higher rating of management capability within those hospitals (as indicated by their survey tool) and that this higher management capability is associated with improved clinical outcomes. In particular, they observed that heart attack survival rates are 9.5 per cent higher in these contested hospitals compared to hospitals not facing competition.

As indicated above there is a body of academic opinion that is strongly opposed to the

introduction of competition and choice into public services. In broad terms the opposition can be categorised as flowing from two perspectives. Firstly, writers such as Allyson Pollock object to the use of competition and choice on the basis that the market progressively undermines "comprehensiveness, universality and equity" (Pollock 2004, p17). David Marquand takes a similar view arguing that putting the delivery of public services into the market domain undermines the service ethic of the public domain which he believes is the true guarantor of quality (Marquand 2004).

This perspective was developed further by writers such as Peter Smith who argued that the Kennedy Report in 2001, into infant mortality at the Bristol Royal Infirmary (BRI) (which identified that failures in organisational culture with respect to safety, accountability, openness and teamwork) means that policy makers can't assume that the objectives of the principal (for instance citizens or patients) correspond to the objectives of the agent (the clinician). He argued that the solutions to the cultural issues identified at the BRI would be restricted by competitive behaviour that would impact adversely on the willingness of professional groups to share experience, learn and undertake activities that are outside contractual requirements.

The second body of opposition to competition in health originates from a more economic/ evidence based perspective. The classic argument for the non-applicability of competition/markets to solutions for health care delivery was articulated by Kenneth Arrow in 1963. Arrow argued that the asymmetry of information between providers of health care and the patient (as the consumer) meant that the patient was unable to seek the best product at the lowest price or to access complete information as would happen in a traditional market (Arrow 1963). As medical science advances this is probably even more the case now than in 1963. In the NHS context it is often argued that general practitioners (GPs) act as agents for patients and overcome the problem of asymmetric information by advising the patient on what is available within the market. But as treatment options become more complex, and GPs become more involved in rationing services to patients through their role as commissioners within clinical commissioning groups, it is becoming less clear that they can effectively fill that role.

Burgess et al (2006) conducted an international review of evidence on the effects of competition between hospitals and other providers, and apart from the United States, they

found limited evidence to conclude whether competition promoted or was detrimental to efficiency or quality. From the US evidence they found that if prices were fixed then quality and costs can benefit from competition. However the research also identified problems that arise from competition.

Firstly, Burgess et al found that the asymmetry of information (which Arrow identified) was evident in the US with the information provided not being in a form that patients could use. The research also identified that there was evidence of cream skimming (where providers tried to attract patients they believed they could treat for a cost less than the fixed fee). This might lead to access problems for patients with more complex needs. The authors considered this to be a potential problem for the UK as PbR could promote provider behaviour that encouraged market entry by providers that delivered a narrow bundle of services for a less complex group of patients (i.e skimming). In addition, fixed prices can create an incentive not to treat more ill patients (dumping) or at the very least not to intervene as actively with this group (skimping).

The body of evidence on the impact of competition in health policy within the UK is slowly building and the international evidence is inconclusive although that from the United States, (mostly from California) is more developed. At present the research from England is inconclusive. The concern is that the research is largely based on data from the period before significant financial pressure was applied to the NHS and the responses of organisations might be very different under conditions of financial pressure.

From the point of view of this research it is clear that competition has the potential to change behaviour, for instance Burgess et al's concerns about cream skimming and dumping of patients potentially impacting upon quality. Marquand's observation concerning the service ethic and Smith's concern about the market driving different behaviours of staff concerning quality improvement. Conversely, competition (when aligned with PbR) might have an impact upon clinicians and managers to minimise the effect on their services from competitors or take advantage of market opportunities to expand successful services. Competition will therefore be a term that is searched in the document review to ascertain if competition has had any effect on the focus of the board of directors of each case study.

3.4 Experience of PbR

The following acronyms are used in this section:

DRG-Diagnosis related group;

ECG-Electrocardiogram;

LoS-Length of stay;

PbR-Payment by Results; and

PPS-Prospective payment system.

PbR is the English prospective payment system (PPS) for acute care delivered by private or public providers but funded by the NHS. As PPSs have been introduced in various health care systems including Portugal, Hungary, Australia and the United States the probable impact of PbR can be ascertained by reviewing some key international literature as well as that from the England.

Farrar and Yi et al (2009) examined whether the introduction of PbR was associated with changes in costs, volume and quality of care during the initial period of the introduction of PbR into the NHS for the years 2003-4 and 2005-6. They concluded that using the proxy measures of quality of in-hospital mortality, 30 day post surgical mortality and emergency re-admission after treatment of a hip fracture there had been no measurable changes in the quality of care. In addition they found evidence that the average length of stay had fallen and day case rates had increased in hospitals subject to PbR faster than non PbR hospitals in the control group (i.e hospitals in Scotland and non FT hospitals not subject to PbR in the early period of implementation). Although total activity had also increased with the introduction of PbR, the research was not able to attribute this increased activity solely to PbR because the government had also introduced performance targets to increase the speed of patient access to treatment at the same time as PbR had been introduced. The research could not separate these effects. Subject to the limitations that the data covers the early period of the implementation of PbR when hospital behaviours might not have fully adjusted to the incentives introduced by the prospective payment system and that the quality indicators adopted might not be easily impacted by quality of care changes (particularly the two mortality indicators) the research

suggests that PbR might create incentives to reduce costs of care delivery and PbR's introduction did not lead to a deterioration in quality.

Shelley and Farrar et al (2011) develop the above thinking further noting that the combination of PbR and the wider NHS reforms introduced in the first decade of this century have been associated with reductions in unit costs, and if the above research is correct, no deterioration in quality. They note that that conclusion does not take account of the transaction and other costs associated with the reforms and the introduction of PbR which they indicate could be significant. They point out that the increase in the level of activity that appears to have occurred in the acute sector, at the same time as the impact of PbR has been felt, may well be more around policy initiatives on waiting times for access (e.g 18 week referral to treatment targets) rather than PbR stimulating increased activity by hospitals as they try to maximise income. They also note that if PbR is to be extended to other specialties then the tariff needs to better reflect case mix (to avoid providers trying to take the easy cases with lower costs (cream skimming)) and tariff setting will have to become more sophisticated.

Dismuke and Sena (1999) noted that in the Portuguese system Diagnosis Related Groups (DRGs) were introduced to replace a retrospective payment system for public hospitals. They reviewed the effect of the introduction of the DRG payment system on several diagnostic processes including the electrocardiogram (ECG). Dismuke found evidence that the length of stay (LoS) for the most frequently occurring DRG's declined. In addition, she noted that the intensity of treatment devoted to each admission also declined. Based upon the three diagnostic technologies reviewed (including EEG) Dismuke concludes the increased use of these technologies may be leading to increased efficiency and productivity.

However, as Dismuke noted, reductions in LoS, or reduced intensity of treatment per admission, do not necessarily lead to greater efficiency. Although Dismuke does not expressly raise the issues of value for money and quality, poorer clinical outcomes caused by reduced LoS need to be taken into account when considering whether improved efficiency has been achieved. She also notes that Portuguese hospitals may have suffered from moral hazard (because of the marginal payment effect) in that hospitals reduce the intensity of treatment per patient in order to avoid having to cover the higher costs. Presumably the incentive will be particularly strong if the hospital's current cost of delivering the treatment is above the relevant DRG (i.e. a loss making activity).

Getzen (2004) commenting on the United State's experience of DRGs observes that the US benefited from a reduction in the rate of increase in costs in Part A Medicare expenditure (i.e. inpatient treatment). He notes this cost control measure had an impact on hospital costs generally, and that the pricing system forced activity into Part B Medicare expenditure (i.e outpatient and day surgery). Medicare has used PPS to apply pressure to control the real increase in prices paid under each DRG.

If the US process of controlling the increase in the annual uplift in prices was applied to the PbR system then this could be used as a driver for promoting greater efficiency within the acute sector of the NHS. This seems a clear possibility under PbR as the tariff setting process for each HRG within PbR for 2006-7 assumed an efficiency saving of 2.5% and in 2010-11 and 2011-12 tariff uplift was only 1.5% and 0% respectively therefore assuming significant productivity improvements (DoH 2011). The tariff has therefore been uplifted by less than NHS annual cost increases to reflect this.

Morrisey and Sloan *et al* (1988) found that there was a dramatic reduction of 9% in the average LoS for Medicare patients in the first year of PPS (Morrisey 1988 p. *52).* This has led Morrisey and others to argue that such dramatic reductions in LoS over such a short period may not be clinically justified.

Steinwald and Dummit (1989) looked at DRG creep, where the average case mix across DRGs of patients treated increases over time. They argue payments to hospitals rise in the early periods of PPS not because of the annual updating process (e.g. increased rates to reflect inflation for each DRG) but because of increases in recorded case mix. They calculate that for the period 1983-88 the cumulative formal update saw less than an 8% rise in payments compared to 20% for case mix charges (Steinwald and Dummit 1989 p.35).

Steinwald *et al* argue that the increased case mix is due to three factors: improved coding; treating more poorly patients (i.e. real change in illness); and intentional gaming of the system. They contend that much of the initial DRG creep in the US was a rational consequence of the system by which the accuracy of coding is improved (as it is the basis of charging). In addition, PPS encourages the treatment of less ill patients in non-acute settings (thus increasing the average complexity of those treated in hospitals).

Anecdotal evidence suggests this is currently happening in the English system. Great commercial emphasis is being placed by hospitals on improving coding (including the

recruitment of more specialist coders) and the move to coding systems based upon the proposed electronic patient record. Procedures, such as simple ophthalmic work, is moving to non-acute care settings leaving more complex procedures in the hospital.

The improvement in coding accuracy by English NHS hospitals has been noted by the Audit Commission in its annual reviews of coding accuracy. Provisional data for the year 2010-11 indicates that of the 30 high risk trusts audited by the Commission 87% of the organisations showed improved coding accuracy for inpatient activity and 83% for outpatient activity (Audit Commission 2011 p.1).

Finally for the US, Ginsburg and Grossman (2005) argue that if PPS becomes misaligned with the average costs of hospitals (for individual procedures) then expansion and contraction of services can occur at variance with patient need. Ginsburg and Crossman particularly identify new technology focussed procedures where productivity in the delivery of the care improves quickly (i.e. care processes improve and updated versions of the technology produce gains). Because individual provider cost information is not readily available in the US, this often results in the PPS system providing hospitals with greater profit margins on DRGs which have made productivity gains. This encourages over provision of those services and can lead to supplier induced demand.

The Ginsburg and Crossman research is based upon interviews with senior managers in the health sector and is not supported by detailed data but if the findings are correct then how PbR operates to distort margins on each HRG may impact on service provision. As PPS in the USA sets DRG payments based on average prices charged by providers (as opposed to average costs under PbR) the degree of variation in margins should be less severe. An annual relative cost index is calculated within the NHS and is used to set PbR payments (DoH 2010).

What may be important in the English system is the impact of HRG payments on early implementers of change. For instance, the wide use of coronary artery stents by major teaching hospitals in the UK was not reflected in the average cost of early versions of the relevant HRG. The impact of this was to significantly increase the risk of expanding coronary services for some major hospitals.

Langenbrunner and Wiley (2002) have looked at hospital payment mechanisms in transition

countries (i.e. the former Eastern Bloc countries) and note that payment system changes create new drivers for hospitals in the delivery of services. They observe that the method chosen to count exactly what a hospital does is fundamental to the introduction of a payment method. The logic is for the care package to be broken down to its constituent parts and the hospital will be rewarded for adding as many ingredients as possible into the patient's care package to maximise fee income. This, as Wiley *et al* note, results in reductions in quality (i.e. unnecessary procedures) and increases in overall expenditure.

Langenbrunner and Wiley also observed that since the early 1990's Hungary has used payment per discharge taking into account types of cases and case mix (i.e. a modification of the USA DRG). Unlike the US system the total health spend is subject to a global expenditure cap and each of the constituent elements of the health system (primary care, outpatient care and inpatient care) have their own monetary caps within the global figure. Wiley also observes that each of the sectors share of total spend has been stable since the system's introduction in 1992.

Experience in Hungary suggests that admissions to hospital may rise. For instance, hospital admissions per 100 rose from 21.8 to 24.2 between 1990 and 1996 (Wiley 2002 p.166). In addition, if outpatient treatment of a condition occurs (as opposed to inpatient) and outpatient treatment is reimbursed at a lower rate (such as the 0.7 coefficient applied to the inpatient rate in Hungary) then there is no incentive to move treatment to outpatient settings. In addition, Hungary has witnessed DRG creep with the case mix index increasing from 0.97 to 1.10 between 1993 and 1996 (Orosz 1999 and 1997).

Langenbrunner and Wiley have also found that excess hospital capacity has increased post the introduction of PPS and it has failed to stimulate structural change in the acute sector. What is also of interest is that they observe that where bed capacity has been removed there has been no corresponding reduction in the number of employees. Physician and specialist doctor numbers increased by 27 and 12 per cent respectively between 1990 and 1996 (Wiley 2002 p.166). They credit the expansion of the medical workforce (during what was a period of difficult employment conditions in the wider Hungarian economy) to structural rigidities in the health care labour market caused by statutory employment protection rights (Public Servants Act and Civil Servants Act).

Goes and Zhan (1995) noted that after the introduction of the PPS for hospitals in California

in the 1980s providers which demonstrated the most effective integration of doctors with hospitals produced lower operating costs. Hurst and Williams (2012) note previous studies, including Burns and Muller (2008), which indicate that doctor and hospital management behaviours that produce integration include, amongst other factors: behaviours which indicate hospital doctors trust the hospital management executives; that there is doctor involvement in clinical decision making;, that consistent doctor and hospital executive leadership persists over time; and that programmes for doctor leadership development are promoted.

Three key concerns therefore arise from the international experiences of PbR. Firstly PbR should promote a shift to greater use of outpatient treatment. The concern would be that this driver could be dampened by reimbursing outpatient treatment at an inappropriately low rate compared to inpatient work. This would encourage the Hungarian effect where total acute sector admissions continued to rise.

The second concern would be the emergence of DRG creep and/or reductions in treatment intensity in some cases. The current concern in the NHS is that acute providers will "game" the payment system so at to maximise reward under PbR. Any rational organisation would wish to achieve full payment for the work it carries out (under whatever system) and therefore FT and non-FTs are recruiting staff to, and improving the quality of, their coding systems. It is likely that at least a one-off transition period of DRG/HRG creep will occur in the UK as coding improves and under-recording of complexity ceases. The question is will the regulatory controls under PbR be sufficient to ensure coding is not "inflated" to an inappropriate HRG?

The final concern would be that because of restrictions on the restructuring of the health worker labour force (as in Hungary) structural change and reductions in capacity (where required) to align costs with PbR tariff will not occur. The Royal Colleges, health sector unions and politically imposed restraints by central government may well stop the acute sector labour force being substantially reduced during any necessary system re-modelling. Recent comment from the media over several thousand potential redundancies in non-FTs (Spring 2010) indicates that political/social restrictions on the ability to reduce worker head count may be substantial. In addition, recent industrial action by public sector workers (including health workers) against changes in pension rights (December 2011) suggests

changes in terms and conditions of employment will be equally problematic.

For the purposes of this research the above evidence suggests that PPS, like PbR, can be effective in reducing costs (for example Dismuke and Sena (1999)). This suggests that PbR could contribute to cost reductions, but does not provide any evidence for how this might be caused. For instance, did the PPS system lead to the alignment of clinical and managerial incentives thus contributing to cost reduction? There is no strong evidence in the above literature that PPS leads to reductions in the quality of care, particularly from the English evidence, for example Farrar and Yi et al (2009). As the semi- structured interviews with clinical and managerial leaders will cover issues of quality, further evidence may be identified as to whether PPS can impact on service quality. It is particularly hoped that this research will build on Goes and Zhan's (1995) and Hurst and Williams's (2012) observations that clinical engagement with cost and income data contribute to delivering reductions in costs .

3.5 Determinants of Hospital Behaviour

3.5.1 External

The NHS has a history of being a centrally funded national service but, as Klein notes, with a desire by ministers to devolve responsibility for how those funds are spent (Klein 2001). A key policy consequence of the desire to delegate management responsibility was the "brisk and decisive" report (Klein 2001 p. 124) commissioned from Sir Roy Griffiths (former chief executive of Sainsburys Plc) in 1988. This report heralded the establishment of a professional group of managers which as Ferlie, Ashburner *et al* (2006) note have become both better paid, subject to tougher appraisal and have much less job security. This group of professional managers have become the leaders of a decentralised NHS.

The process of decentralisation of the NHS has been progressive, firstly by the creation of NHS Trusts which, while still accountable to the Secretary of State (SofS), became legally responsible for the staff they managed and the services and care they provided (DoH 1990). In 2004 this decentralisation was further extended with the creation of FTs which were no longer accountable to the SofS but notionally to their members (via governors elected from their membership) and the regulators (in particular Monitor the FT regulator) and ultimately to Parliament (DoH 2003). As Dr John Reid (the then SofS) noted *'Parliament would have*

to address their questions to the Trust chair" and by implication no longer to an elected politician (Edwards and Fall 2005 p.191).

In tandem with the movement to greater operational control of the delivery of NHS services to hospitals (by NHS Trusts or FTs) there developed an NHS culture of target setting and assessment of organisations against those targets. And as Flynn notes the NHS has mostly shown improvement as 'targets concentrate efforts to their achievement" (Flynn 2009 p.271).An example of this target setting is the accident and emergency maximum four hour waiting target which the NHS has generally achieved. Professor Steve Kelman, when noting the impact of the measure found that the use of the target to be an "*efficiency enhancing improvement in treatment technologies*" (Barber 2007 p.170).

In the case of NHS Trusts, organisations have been performance managed against those targets by strategic health authorities (Higgins and Bradshaw *et al* 2005) and in the case of FTs by the FT regulator, Monitor (Monitor 2011a). The process of establishing a professional cadre of managers, decentralising operational control of the NHS, and the use of performance management, have become key elements of the phenomenon known as new public management (Ferlie *et al* 1996).

The FT regulator's role is two fold. Firstly, it is responsible for the authorisation of an NHS Trust to become an FT, assessing an organisation's capacity and capability to operate as an autonomous NHS healthcare provider independent of the powers of direction of the SofS. Secondly, when it has authorised the provider, Monitor regulates the operation of that FT to ensure it complies with its terms of authorisation (Talbot-Smith and Pollock 2007 p.112). Through its role Monitor considers itself to be able to bring significant external pressure on organisations as evidenced by its effective action with regard to thirty FTs with performance issues since 2004 (Monitor 2010 p.1).

In the event that Monitor determines that an FT is in 'significant breach' of its terms of authorisation Monitor has wide powers under section 52 of the Health and Social Care (Community Health and Standards) Act 2003 to require specific action of the board of directors, and in some cases removal of members of the board. For example , the removal of the chair of the board of directors of Bradford Teaching Hospitals Foundation Trust in 2004 (Talbot-Smith and Pollock 2007, p113) and Colchester University Hospitals NHS Foundation Trust in 2009 (FTGA 2010).

The other main regulatory pressure on FTs is from the care quality commission (CQC) and its earlier incarnations i.e the Commission for Health Improvement. The CQC sets minimum standards for care processes (e.g respect and dignity) and then inspects FTs for compliance (Walshe 2003). The CQC has the legal power to stop FTs providing services if the FT fails to meet the standards of registration (CQC 2009) although to date Monitor has acted as the lead regulator for FTs and the CQC's concerns have been channeled through Monitor : for example, quality concerns at Basildon and Thurrock University Hospitals FT were formally actioned through a Monitor section 52 notice requiring specific quality improvements (Monitor 2009a). Therefore, although FTs will be subject to external pressures from various parts of the health sector, for example the CQC and vested interests such as the British Medical Association and various Royal Colleges, Monitor appears to be a very influential external influence on FTs.

3.5.2 Internal (governance)

The governance structure of FTs removed accountability to the DoH and replaced it with compliance with a regulatory framework (discussed above) and local accountability to the members and governors of the FT. Dixon and Storey et al (2010) conducted a study which examined how FTs were being held accountable and by whom. The research based upon interviews with 75 respondents (mainly FT directors and governors) between 2006 and 2009 found that vertical accountability to the DoH had been replaced by accountability to the Council of Governors who were elected by the FT members to hold the board of directors to account for the performance of the FT. This is similar in many ways to the way in which shareholders hold the directors of private and public companies to account for the delivery of the strategic objectives of those companies. The research concluded that the ability of governors to effectively hold boards of directors to account was weak and in the absence of effective primary accountability to the governors at local level the FT regulator, Monitor had to a large extent filled the gap. The research concluded that FT boards of directors continue to look upwards in terms of accountability to Monitor, rather than downwards to their members (via the governors of the FT) and other local accountability mechanisms such as accountability to local commissioners of NHS services (i.e primary care trusts at the time the article was written), Overview and Scrutiny Committees and Local Involvement were also considered to be weak.

Allen and Keen et al (2012) looked at four case studies involving over a hundred interviews, observation of meetings and review of NHS documents) to explore the impact of external governance and internal governance on the FT case studies. The research noted that although FTs outperform NHS Trusts that performance pre-dates the move to FT status. In terms of the impact of FT external governance (i.e freedom from the traditional DoH performance management but subject to operating within a regulated quasi-market subject to the Monitor licence) the research found that the potential for Monitor to use its intervention powers affected the behaviour of FT directors when it came to the focus on the relationship with Monitor. With respect to internal governance and the board of directors accountability to the members and governors of the hospital governors interviewed had mixed views about their ability to hold the board of directors to account for the performance of the hospital. The research also noted that the ability of FTs to retain any surpluses generated by PbR made PbR as a mechanism influential on the FT. The research noted that the national tariff under PbR produced incentives to reduce costs but that some clinicians had concerns about this incentive as it translates practically into a push to discharge patients early.

The internal governance results noted by Allen and Keen et al (2012) above were supported by Lewis and Hinton (2008) in their one -year case study of Homerton Hospital in London. The study involved interviews with governors and directors, observation of meetings and a review of documents. The authors noted that the governors' perception was that they had little impact on the decisions of the hospital during the case study period and both directors and governors lacked clarity on the role of governors. This lack of clarity as to governor function significantly restricted the development of the new governance model potentially leading to an accountability gap. Vertical accountability to the DoH had been removed but local accountability to the population served by the hospital was not fully developed.

Anand and Exworthy et al (2012) also conducted research based on 52 interviews with senior NHS managers and explored the extent to which FTs had the incentives and capacity to respond to the increased autonomy provided by FT status. They noted that the independence provided by FT status (for example the ability to retain cash surpluses) provided an opportunity to develop and improve services for those managers who wanted to, but that increased autonomy does not imply that it will be exercised. This is particularly if FT managers are risk adverse and those managers perceive that they are more individually

exposed by exercising that autonomy rather than diffusing their responsibility upwards through a hierarchy. The authors argue that this risk averseness of managers has to some extent restricted the delivery of the policy objective that FT autonomy would promote innovation. FTs have the legal ability to exersise discretion but a combination of NHS managers having operated for long periods of time in a centralised culture, having limited entrepreneurial skills and capacity, and the fear of destabilising good local relationships has inhibited FTs' willingness to exercise that autonomy.

The above research suggests that due to failures in the internal governance regime for FTs (be it due to cultural behaviours of NHS executives to look to Whitehall for command and control or the increasingly directional approach of Monitor due to the perceived inability of governors to hold boards of directors to account for the performance of their FTs) FT boards of directors are significantly influenced by Monitor. As part of the semi-structured interviews, and the documentary review, these issues will be further explored.

3.5.3 Internal (clinical and managerial)

In addition to governance structures impacting on organisational behaviours individual staff behaviours will clearly have an impact.

A review by Addicott (2011) into social enterprise in healthcare looked at how a combination of local autonomy (for instance through a social enterprise either directly owned (e.g share ownership) or indirectly owned through a trust structure) combined with staff engagement can contribute to innovation. For the purposes of this research one of Addicott's key conclusions was that theoretical staff enpowerment, for instance through direct or indirect ownership of a social enterprise, does not itself lead to staff engagement and innovation. Addicott noted that one of the key policy drivers for promoting the social enterprise policy in health is to bring employee involvement into decision making and she noted that the literature supports the view that it is the staff engagement in decision making which is associated with a stronger tendency for social enterprise innovation rather than staff ownership of the organisation. From her interviews with FT chief executives she concluded greater staff engagement with decision making was being developed, for instance the introduction of service line management (where business decision making and accountability rests at service level with

staff being more engaged in decision making). The question for this research is the degree to which PbR in the four FT case studies has contributed to staff involvement in decision making and therefore innovation and productivity.

Graham and Steele (2001) have looked at the motivation of doctors and managers. They conducted a survey of 85 managers and 44 doctors in which they had to prioritise thirteen motivating factors. Hospital managers, general practice managers and hospital consultants all prioritised the 'desire to deliver a good quality service' as their top priority. GPs within the group prioritised 'working in a productive team' as their top motivating factor. It would appear that, at least in the hospital context, this gives some support to the belief that clinicians and managers are working to the same broad objectives. In earlier research Steele conducted a survey of managers in the public, private and not-for profit sectors involving detailed interviews with over 400 respondents either in person or by telephone. The most common goal identified by public sector managers was to provide a service to the community (1999). In terms of manager motivation this lends support to Steele's later research above.

If we move our attention to clinical motivation Mathie (1997) conducted questionnaire research based upon 42 responses (a small sample) on what motivated consultants to adopt change within their working environment. The main findings were that clinicians are motivated to change behaviour if it frees up time and the change is perceived to improve the quality of care. It is not surprising that time is a high value commodity for clinicians but it is interesting that they appear, from this research, willing to adopt change in order that they have more of it. The question would be what would they use that released time for: more public work; private work; or leisure and family?

Nantha (2013) looked at the intrinsic motivation of doctors (i.e the ability to pursue an activity/challenge based on ones interest and ability to do so) rather than providing tangible rewards. He argues that clinicians perform best when intrinsic motivation is maximised arguing that cultures of standardisation (thus reducing clinical autonomy) deadlines, environmental pressure and financial rewards undermine intrinsic motivation and therefore reduce clinicians performance. This is supported by Humphrey and Russell (2004). They interviewed 60 surgeons and physicians (who had NHS and private practice earnings) with the objective of identifying what was attractive to them in working in private practice compared to their NHS role. In addition to the financial reward associated with personal self

interest the respondents identified strategic influence (as they brought in paying clients), clinical autonomy (they could select their own teams), a sense of being valued (they received peer approval by being asked to work with colleagues) and ability to realise their individual clinical aspirations (ability to innovate and try new approaches) as reasons for working within private practice. This latter research provides real incite into clinical motivation.

From the point of view of this research project the above results suggest that if PbR allows clinicians to enagage in decision making with general managers(providing strategic influence) and clinicians acquire greater respect for engaging with that process (peer approval) then it is possible that clinical engagement with PbR might be effective.

CHAPTER FOUR

DOCUMENT REVIEW

'The fish rots from the head'

Chinese proverb

4.1 PURPOSE

As indicated in chapter Two, the research set out to investigate whether the introduction of PbR in four acute sector FTs led to an alignment of clinical and managerial incentives leading to improved output, quality, quantity and productivity (and if so) the reasons for this. A document review was undertaken as part of a triangulation of data which included interviews with senior NHS staff (see the next chapter), a review of board minute documents (set out in this chapter) and a high level analysis of productivity data (set out in chapter six).

The objective of reviewing the board minutes was to identify the degree to which the boards of directors, as the directing mind of each of the four case studies, had focussed upon activity, quality and productivity issues during their time as FTs and to identify any changes in that focus over the period of the research. In addition, it was hoped that an indication of possible drivers for that focus would be identified.

4.2 METHOD

4.2.1 Board minutes in context

Prior to the creation of FTs the vast majority of issues discussed in formal board meetings were minuted in some detail and made available for public inspection. This has resulted in board minutes being readily available on the websites of NHS organisations and historically has led to relatively straightforward access to board-level documentary data.

As the board minutes of NHS trusts are generally detailed they provide an excellent source of information with regard to why decisions are made and the concerns expressed in coming to those decisions. In addition, as the boards of NHS trusts are unitary (i.e. they contain executive and non-executive directors who have the same statutory liability under the law) the challenge that good non-executives bring to the decision-making process assists in identifying the motives and rationale for decisions. Due to issues arising from personal legal liability for negligent decisions non-executives are often keen to have the full reasons for decisions recorded to prove due diligence and limit their legal exposure. This makes NHS board minutes a potentially rich source of data.

The traditional limit to this extensive disclosure has been matters reserved to what are technically known as Part II of the board meetings where issues of a highly commercial or delicate clinical nature would be discussed in private. Part II elements of NHS board meetings have traditionally covered a small number of issues (often because the Chairmen of these organisations have believed in transparency in public service decision-making) and under these conditions Part II constraints would not have been material in limiting the effectiveness of documentary reviews in identifying a board of directors' focus and motives.

With the creation of FTs, and the modus operandi of the new organisations believing that they operated in a quasi-market environment within the NHS, there was a significant risk that large amounts of detail would be omitted from the Part I minutes of the FT (fully disclosable) and moved into Part II of the meeting. This concern was tested by reviewing a small selection of board meeting minutes of each case study prior to attaining FT status and identifying the degree of change.

If this had proved to be a material concern then the case study trusts would have been approached for access to Part II minutes or, ultimately, the disclosure provisions of the FoI (2000) could have been used to require disclosure. In the event neither of these options were required as the case studies continued to report in a broadly similar way.

As the quasi-market for health becomes more established there may be an increasing amount of information that is placed in the Part II agenda and a reduction in the number of public board meetings. This could well impact on future research that uses FT documentary data.

As indicated in chapter Two it would have been possible to search other types of documents as part of the review. In particular, a review of the operational management team minutes (often referred to as HMT) could have been undertaken as HMT deals more with the operational delivery of the services and often involves clinicians and management in the decision making process. These documents may have been a good source of data.

However, two practical reasons made access to these documents unrealistic. Firstly, HMT minutes are not considered by hospitals to be public documents and therefore gaining access to electronic versions of this material would have involved significant additional time costs both for the researcher and hospital staff. Secondly, the chief executives of each of the case studies made access to their hospitals conditional upon ensuring that, apart from the interview time given by senior management, the research would not involve further resource implications for the FTs. The provisions of the FoI could of course have been used to secure access to the documents but this would no doubt have led to the withdrawal of co-operation by many of the case studies and as Machell, Gough and Steward (2009) note, effective boards will ensure key issues resulting from debates in committees, immediately below the board, are formally reported to the board. If good corporate governance is being followed this information will be recorded in the board minutes.

The document review looked at a selection of board minutes made available on each case study's public websites for a period of twelve months prior to the date of September 2007. The cut-off date of September 2007 for the end of the documentary review was chosen as it provided sufficient data to review and sufficient time for initial results of the review to inform the content of the semi-structured interviews discussed in chapter five.

4.2.2 Search terms

The next step after selecting the appropriate documents to review was to identify the phrases, words or context to search. On the basis that the central research question was looking at issues around PbR, quality, quantity of output and productivity these words, and a series of words and phrases commonly associated with the concepts, were searched. The phrases were identified in two main ways. Firstly, the central research question key words, for example 'PbR' were noted, and as part of the literature review, phrases that were commonly

associated with the central research key terms were recorded and used in the documentary search. For example, Department of Health (DoH) technical guidance on PbR for the financial year 2003-4 extensively used ‘tariff ‘ as a substitute for price under PbR (DoH 2003). Tariff was therefore used as a search term. The second approach was to search key terms in the central research question in the Collins English Dictionary. For example, a phrase associated with ‘productivity’ in the Collins English Dictionary is to ‘maximise output’ (Collins 2007). This phrase was one of the additional search terms identified in 4.2.3 below.

An anonymised example of the search criteria, search results and an example board minute with highlighted search results are set out in Appendix One and Appendix Two respectively.

The original search focused upon productivity and involved a search of the words productivity, cost control (i.e control of the inputs to the production process) and efficiency which technically is the focus upon the process of production but in the health service is used loosely to mean productivity in many circles. As is explained later in this chapter the search criteria for identifying focus on productivity were extended.

As the research was looking at the drivers for productivity improvement the use of the word productivity represented a good starting point. Historically productivity has not been a term used in everyday operations of the NHS and therefore alternatives were sought which were constituent parts of the productivity equation. As mentioned, efficiency was identified as an alternative to productivity as it focuses upon the production process using the inputs. In addition, the search included cost control, a common term; focus in the NHS is a focus upon the inputs of the production process as reflected in the institutionalised cost improvement programme..

The documents were also searched for possible drivers for productivity including financial balance, quality, service line reporting, the regulator Monitor, Payment by Results and Value for Money. In the case of payment by results the abbreviation PbR was also searched as was SLR in the case of service line reporting.

As NHS trusts had historically had a statutory duty to balance revenue and expenditure over a three-year period (often referred to as financial balance), the researcher concluded this might be a strong potential driver for boards of directors looking at productivity.

As quality of care had been a strong focus of government policy since the NHS Plan had been introduced in 2000 quality of care was thought to be a potential driver for improvements in productivity as doctors (and clinicians more generally) were seeing the process of care (i.e. the series of interactions the patient is exposed to during treatment) as being critical to quality, including reducing delays in that journey without any increase in inputs. All things being equal this would be a driver for productivity.

It was also felt that Monitor, as the lead regulator of FTs, had a unique power over these organisations in that the regulator could cancel an organisation's right to operate by revoking its licence and had wide statutory powers of intervention including, but not limited to, the removal of members of the board under Section 52 of the National Health Service Act 2006. With this power of intervention it was felt Monitor might be able to affect an FT's operational behaviour and the board's focus. Monitor was therefore used as a search term.

An example of the potential influence of Monitor is exemplified by Monitor introducing the concept of service line reporting (SLR) into the FT sector of the NHS. Historically, the NHS has operated large businesses (often larger than many FTSE 250 listed companies) without understanding the individual cost components of a patient's treatment and the associated payment that the hospital receives for providing that intervention. SLR is the process by which cost data is collected on clinical areas are compared with the associated revenue allowing the effective management of individual services. Monitor anticipates that SLR will lead to improved financial performance as a consequence of improved reporting to management teams and boards of directors, and resultant productivity improvement. As well as searching Monitor in the documents, the researcher concluded that SLR would also be an appropriate search term.

The final driver of productivity searched in the board minutes was Payment by Results. As explained in Chapter One this is the prospective payment system by which acute trusts receive payment for the services they provide to commissioners. Since 2006-7 the payment system has been uplifted by at least 2.5% less than the rise in the average costs of delivery of those services. As this payment system is fundamental to the financial sustainability of the FTs it would be expected that boards would be focusing large amounts of attention on ensuring that the services they deliver were being delivered at, or below, the payment received under PbR (i.e. below or at tariff). PbR was therefore searched within the board

minutes.

As many of the search phrases and words were often mentioned several times in one sentence (but clearly only referring to one event) the search method used required not only identifying the phrase word used but also analysing the context in which it was used. Directors also have words in their job titles, for instance quality, which would over emphasise quality as a board focus if the method used to review the documents was not able to contextualise the initial results.

As outlined in Chapter Two, three options were identified for conducting the document search: NVIVO 7, Atlas.ti 5 and Microsoft Word search facility. The three options were trialed for effectiveness but the researcher found that the systematic word search offered by Microsoft Word allowed investigation of the context in which the word was used (for example, occurred within a director's job title) and also permitted a judgement to be made as to whether the repeated use of the word or phrase represented a new occurrence or merely a repetition in the identical context.

In order to test the methodology of using Microsoft Word as the search technique a selection of documents were searched by the researcher. A third party then conducted the same search using the same methodology and the results were compared. In each case, the results of the searchers produced the same number of positive search results identifying the same explanation of the context.

As previously mentioned, the context in which the word or phrase occurs in the document search is significant and the research methodology employed therefore required a means of identifying not only, where and how many times the search term(s) were used but the context in which they were used. For example, it would be misleading, if a search result for 'quality' were recorded and interpreted as the board having a meaningful conversation about the quality of care if the word 'quality' had merely been recorded because it was in the title of one of the directors of the board. For this reason all the documents were read by the researcher at the time the word search was conducted. This approach also provided assurance to the researcher that board conversations concerning subjects such as productivity had not been unrecorded merely because the search term had not been written in the board minute. The unintended consequence of this approach was that the researcher also built a wider understanding of the agenda faced by each of the case study organisations. This

understanding helped the researcher build empathy and engagement with the interviewees during the interview process. All the above search criteria were used in the initial search of the documents. On completion of the first set of document searches using these criteria there was a clear lack of focus by boards on productivity and related terms. In order to ensure that the selection of search terms was not too narrow, and therefore under-recording the focus of boards on productivity and related issues, a second review of the documents using additional search criteria was conducted.

4.2.3 Additional search terms

As set out in 4.2.2 above, the search terms and phrases were identified by a combination of using the literature review and dictionary searches. This process was also followed with the additional search terms but a wider perspective was employed given the results of the first search had produced limited evidence of engagement with productivity. For example, in selecting the additional search criteria the intention was to identify words and phrases that were part of the concept of productivity and in the case of PbR, could be used as a proxy for price. Price itself was not used as a search term as FTs are not operating in a pure market environment and there is a general reluctance by boards to use normal market terms within the service.

In the case of productivity the above process produced additional search phrases that were related to the maximisation of output or minimising of costs. The researcher identified the following additional terms to be searched in the second review: maximise revenue, maximise income and maximise output. With regard to inputs, the phrases reduce costs, cost improvement programme (CIP), length of stay (LoS) and value for money (VFM) were also searched. Although CIP is not technically the same as productivity, but VFM is, the NHS has a tendency to use the terms loosely and it could therefore be considered a proxy for productivity.

The second set of search terms also sought to identify the degree to which the quasi-market in healthcare in England was having an impact on board focus on productivity. The documents were therefore searched for competition and choice.

As the central theme of the research was PbR, and the results of the first searches indicated this concept was receiving very limited attention by the relevant boards, the search criteria of

tariff (often used as an alternative to price by NHS finance professionals) and relative cost index (RCI) (an indicator of relative cost performance, please see Chapter Six) were also searched.

As a consequence of adding the additional search criteria each of the 80 documents reviewed have been subjected to 20 different search terms, as opposed to the 11 which were conducted initially, and this has provided the document review process with significant rigour. The initial findings as to board focus have been robustly tested by the second series of searches.

4.3 EXAMPLE METHODOLOGY

The process followed in the review of the documents is set out in Appendix One and Appendix Two by reference to an anonymised set of search criteria and results and an anonymised board minute respectively. In the case of the search terms and results in Appendix One in each case the abbreviated phrase, in brackets, is searched as is the full term. For example, each search for item one consisted of a search for PbR as well as a search for Payment by Results. The number of positive results is then set out in column two of the results table. Column three of the table then states the context in which the term is mentioned. For instance, in the example in Appendix One quality is mentioned twice. It is first raised in the context of the hospital's strategy improving the quality of patient care and then with regard to quality improvements being linked to financial actions.

Appendix Two, which has the board minute which relates to the search criteria and results in Appendix One, shows the context in which the search result has been identified - this is shown by the highlighted test in the board minute. This allows the reader to cross reference the example results in Appendix One (including the context used) with the document searched. This process has been repeated with each of the documents searched.

In addition to the recording of the occurrence of each of the search terms in each board minute reviewed the researcher then added together the number of occurrences of each search term in all the board minutes reviewed for each case study. This number was then divided by the number of board minutes reviewed for that case study to give an average incidence of the term for the total number of board minutes reviewed for each case study. For example, if quality had been recorded a total of 24 times across all the 20 sets of board minutes reviewed for a case study then the incidence would be recorded as an incidence of 1.2 (i.e 24 divided by

20). The incidence of all the search terms, for each case study, are recorded in Table 4.1 below.

4.4 RESULTS

4.4.1 Document search results

Table 4.1 below sets out the average incidence of the search results for each of the case studies. In broad terms incidence of a term being recorded in the minutes of every board meeting reviewed would be denoted by a value of around one. For instance, the average incidence of 'cost control' in each of the studies varies between 0.9 and 1.18 for different case studies; this indicates that board focus on cost control was mentioned in most board meetings for each of the case studies. In contrast, 'value for money', generally associated with a consideration of cost relative to the quality of what is provided, was never mentioned in the minutes of any of the board meetings. Was this a possible indication of the lack of sophistication in many board debates? The results from the review of the board minutes of the four case studies are set out below.

Table 4.1

Average Incidence of Document Search Criteria

	Case Study	**Case Study AA**	**Case Study BB**	**Case Study DD**	**Case Study CC**
	Word/Phrase Searched				
1	PbR/ Payment By Result	0.64	0. 7	0.5	0.14
2	Productivity	0.27	0.24	0.35	0.30
3	SLE/SLR	0.27	Nil	0.13	Nil

	Service Line Economics/Reporting/Management	(March/April 07)			
4	Cost control	0.9	Nil	Nil	0.16
5	Quality/measuring quality	0.45	0.9	0.62	0.81
6	Financial balance	Nil	Nil	Nil	Nil
7	Efficiency	0.8	0.7	0.32	0.08
8	Monitor	2.45	2.7	1.4	1.3
9	Maximise income/revenue/output	0.73	0.5	0.41	0.27
10	Reduce costs	0.83	Nil	Nil	0.08
11	Cost Improvement Plan (CIP)	0.9	0.2	0.23	Nil
12	Length of Stay	0.64	0.8	0.61	0.46
13	Tariff	1.0	1.21	0.9	0.48
14	Relative Cost Index (RCI)	Nil	Nil	Nil	Nil
15	Value for Money	Nil	Nil	Nil	Nil
16	Choice	0.2	0.08	Nil	0.4
17	Patient Choice	0.2	0.08	Nil	0.1
18	Competition	Nil	Nil	Nil	0.1

Notes:

a. Average incidence per document reviewed.

b. Where alternative search criteria are listed in the table each document has been searched for each option separately.

4.4.2 Document search results key observations

The main results from the document search indicate that PbR or the concept of tariff which is often used as an alternative for PbR, was on average mentioned in every board meeting in case study AA and BB and slightly less than every board in DD. An interesting observation is that in case study CC the frequency of reference to PbR or tariff is half that of the other three case studies. Prior to May/June 2007 there is no indication from the board minutes that the boards of the case studies conducted a review of costs, income and output in a systemised way. Two of the Trusts indicate initial interest in more systematic financial reporting in May 2007 onwards where service line reporting starts to be mentioned. This may have been stimulated by Monitor's support for service line reporting.

With regard to the key issue of productivity, on average the concept is noted in one in every four of all board meetings for each case study and the context in which it is raised in all the case studies does not indicate a holistic understanding of productivity (the interaction of inputs, process and outputs) but rather the interchangeable use of the term with concepts like efficiency. There is no indication that productivity was the cornerstone of decision-making within any of the case studies.

The document search included a commonly used process measure for productivity (length of stay 'LoS') as it is possible that boards might be focusing upon the ingredients of productivity but not using the term itself. It is interesting to note that case study AA was twice as likely to consider LoS than its nearest rival BB which mentioned LoS about once in every four board meetings. Case study CC did not mention LoS at all and DD about once in every five meetings.

Conversely, the concept of efficiency is referred to much more regularly in case studies AA and BB but in the case of CC and DD efficiency is referred to in line with that of productivity: in the case of CC on average one in every three board meetings (or once every four months) and DD about once a year. Except in the case of BB efficiency is usually referred to in the context of the centrally assumed funding assumption that hospitals will achieve a specified efficiency saving (for instance 2.5%) and this assumption is taken into account when setting the tariff for procedures under PbR. This efficiency assumption often translated into a focus upon a reduction in input costs as opposed to improved processes.

As mentioned above, all the case studies were subject to the central assumption that they would achieve efficiency savings, for example 2.5%, and the conventional method employed by the NHS in achieving this was to introduce hospital level cost improvement programmes. It was therefore expected that reference to 'cost improvement programme', or CIP or 'cost control' would be a common features of the board minutes. Although 'cost improvement programmes' were mentioned in approximately one in five board meetings for case studies BB and DD it was clear that case study CC did not refer to its CIP. Nor in the case of CC did the minutes refer to 'cost control' more than once or twice during the period and the same with 'reduce costs'. The absence of focus on 'cost control' and 'cost reduction' was also shared by BB and DD. Case study AA was the clear outlier with respect to focus upon its cost improvement programme. In AA's case its CIP was mentioned in nearly every board meeting.

In addition to AA's focus upon its CIP the minutes also indicate that AA also referred to 'cost control' and 'reduction in costs' as the concepts were referred to in a large majority of meetings.

It should be noted that the concept of financial balance (the traditional objective of NHS trusts) and the relative cost index (RCI: a key indicator of the relative cost position of an English hospital relative to its peers) are rarely mentioned and the minutes of several case studies which the researcher reviewed never refer to the concept of RCI at all. The concept of value for money (i.e the consideration of the benefit gained from an action compared to the cost of delivery), a notion which the Audit Commission has promoted for more than a decade, was not referred to once in any of the meetings searched.

In the decade of plenty for NHS funding it might have been expected that, rather than a focus on cost control, the FTs might have focused on maximising income/revenue. In case study AA income maximisation was discussed regularly. In the other case studies, income maximisation was not mentioned at all in case study DD, about once in every ten meetings for BB and once in every three meetings for CC.

It would also appear that the traditional target for boards of achieving financial balance (that is income and expenditure being broadly in line) was not a focus of the case study boards as no results were found for this concept in all the documents. An explanation of this might be that within the financial regime under which FTs operate there is an expectation by Monitor that, rather than being in financial balance, FTs should generate significant surpluses to

support capital and service developments. If this is the explanation, it is interesting how quickly FTs moved from the constraint of financial balance not only in the practical sense but also in the use of a vocabulary that had been commonplace since the creation of NHS Trusts in the early 1990s.

As the results from the document search did not indicate a strong emphasis on productivity in the financial sense, the document review turned its attention to the quality agenda and the degree to which these boards had focused on the quality of output given the DoH's support for quality improvement during this period. A strong indication that quality was the focus of board attention could of course still lead to evidence to support the notion that productivity was at the centre of the board's attention in the case studies but that focus was on the quality of outputs as opposed to minimisation of input cost.

As the quality agenda was at the fore of central government policy during the period of this research, and productivity was receiving little airtime either in DoH directives or in the media, it is not surprising that the occurrence of quality in the board minute review showed a positive occurrence in all sites, with quality being mentioned at least once in every other meeting. Given the profile of quality in the government's agenda it is surprising that it was not more prevalent than the results indicate.

It is worth noting that when quality was mentioned it was rarely focused upon improvements in quality of outcomes or pathways of care. Often the discussion concerns external proxies for quality such as complaints or patient surveys.

Although proxies for quality appeared to be of interest to the boards there was no clear link of quality to productivity. In this connection it is worth noting that FT AA, which had the highest focus on CIP and cost control terms, mentioned quality significantly less often than the three other case studies .

Part of the quality agenda has been the control of infection within hospitals, in particular MRSA. Although not a search term of the research, it is interesting to note that MRSA infection rates are regularly recorded in the board minutes of all the case studies. There is a strong argument that this is a fundamental aspect of quality but the focus of discussion at boards appears to be on achieving the individual FTs target to comply with regulatory requirements as opposed to a wider quality agenda. This observation will be expanded upon within Chapter Seven, the Analysis Chapter.

Although reference to quality was a more common finding in the board minute search than factors associated with productivity, the most interesting result from the document search must be the finding, across all four case studies, that Monitor (the independent regulator of NHS FTs) was by far the most commonly observed search result. On average the regulator was mentioned in every board meeting across all four case studies and in those case studies which had faced any form of performance issue, or had had a more recent authorisation from the regulator, the occurrence was two to three times higher. Case studies AA and BB were particularly focused upon the regulator.

In most of the instances where Monitor is mentioned it is with regard to complying (or otherwise) with business plans and regulatory submissions. The focus upon these submissions is an indicator of the seriousness with which the relationship with Monitor is taken.

The degree to which Monitor is able to influence FTs, and possibly guide the productivity agenda, was explored in some detail during the interviews, as was Monitor's encouragement of FTs to invest in better financial management reporting in the form of service line reporting and management. What is interesting, and to some extent surprising given the prevalence of Monitor discussed above, is that SLR (a key interest of Monitor) does not appear to have been an area discussed at board meetings to any significant extent. Case studies BB and CC do not mention such reporting at all.

In the search for potential drivers of productivity other than PbR the documents were searched for indicators that a quasi-market for healthcare was having an influence on board focus and perhaps driving the productivity and quality agendas of the hospitals. Three terms were therefore searched namely competition, patient choice and choice. The concept of competition appeared not to be recorded at all in three of the case studies during the period covered and in case study CC very occasionally. The terms choice and patient choice also appear to have had a limited impact on board discussion although choice was discussed more frequently in the case of CC. During this period 'Choose and Book" (the system by which patients were provided with a system to choose a hospital for treatment) was being implemented within the NHS.

Although the analysis of these results will be conducted later in this chapter it should be noted at this stage that the document search results indicate a relatively limited occurrence of terms which might indicate to the reader that the FT case study boards were focusing on the

delivery of efficient healthcare by discussing issues of productivity. This broad conclusion is in line with the productivity indicators set out in Chapter Six.

4.5 LIMITATIONS OF DOCUMENT REVIEW

The research identified the board minutes of the four case studies as a primary source of data as to the operational, and strategic, focus of the relevant organisations. In choosing this data source the researcher has assumed that the content of board discussions are accurately recorded within the FT's board minutes and that the analysis that has led to the decision has been discussed within the formal board meetings. In private sector board meetings (and to some extent in the public sector) much of the analysis that leads to decision making by boards often occurs in non-documented strategy meetings and more informal settings between members of the board.

In the NHS this limitation is to a large extent countered by the desire of NHS boards to demonstrate how and why decisions are made to meet their (often natural) inclination to demonstrate public accountability. This tends to result in the production of large detailed documents at formal board meetings which bring together much of the behind-the-scenes analysis which has had an impact on the decision and the key drivers are then recorded in quite full board minutes. This limitation is therefore not thought significant in the context of the research.

The second limitation is the degree to which the document search itself focused upon the correct key words and phrases. As previously mentioned the documents have been subjected to two sets of searches to ensure that as wide a search selection as possible has been applied. As the results section of this chapter demonstrated, the findings from the first series of document searches indicated limited focus on productivity by boards. This resulted in the application of additional search criteria to ensure that the results were not being prejudiced by too narrow a selection of search terms.

The third key limitation is the degree to which the search of the correct documents has been made. By reviewing board minutes the implicit assumption of the research is that the board of directors (as the body responsible for the performance and governance of the organisation) should be focusing upon the key issues which face an NHS Foundation Trust. In particular,

the quality of services provided, long term financial sustainability (which in an environment of real terms reducing tariff must indicate the need for improved productivity) and regulatory compliance.

Critics of traditional NHS boards would argue that the real decisions affecting hospital behaviour are taken by the Department of Health and that the executive management teams of hospitals merely implement those decisions irrespective of their boards. If this was to be the case then the content of board minutes might be considered a poor source of data. As the research reviews NHS FT board minutes, and FT boards have all been through the rigorous basic competency tests applied by Monitor to ensure they are capable of running their hospitals independently of the instructions of the DoH, this particular concern as to the appropriateness of the documents search is partially allayed.

The fourth limitation is whether the research focused upon the minutes of the correct meetings within the case studies themselves. This limitation falls into two parts; firstly would a review of meetings of the operational management team (often referred to as HMT) have given a more accurate indication of the focus of the organisation rather than reviewing board minutes; and/or should the documentary search have reviewed the minutes of the board of directors sub-committees (such as finance and performance, audit or quality and risk) as those minutes might have provided a more granular understanding of the issues facing the organisations.

It may be of course that HMT, or the board sub-committees such as finance and performance, might have demonstrated more day-to-day focus on productivity and related issues but in environments where good corporate governance is practiced (as should be the case in the FT sector as a result of the robust FT authorisation process) this should still leave the high level discussions about productivity and quality occurring at board level.

If the research had also included searches of the HMT and board sub-committee minutes this may have produced verification (or otherwise) for the results of the review of the board minutes. As indicated in Chapter Two, the constraints of access rights to the data, time and resources of both the hospitals and the researcher made this unachievable. As previously mentioned, the HMT and board of directors sub-committee minutes are not a matter for public record therefore the case studies would have had to have been supportive of the document disclosure or the provisions of the FoI Act would have had to be used. As the

management teams of the four case studies had been very supportive with their time and access rights such approaches would have been counter-productive to generating support for the interview stage of the research.

The reader will recall that the documentary review produced the unexpected result that significant board focus was concentrated around the relationship and requirements of the health sector regulator, Monitor. Although the regulator is mentioned with significant regularity in all four case studies, case studies AA and BB recorded three times the number of references to the regulator as CC and DD. As noted in the results section, this high degree of focus on Monitor by case studies AA and BB is likely to be a consequence of AA having recently been through the FT authorisation process and BB facing the threat of regulatory intervention due to risks to its financial stability. Caution must therefore be exercised when interpreting the significance of Monitor in respect of these two case studies. Although the timing of the data collection no doubt had an impact on the research results for these two case studies it is still significant to note that case studies CC and DD also record a high level of focus on Monitor and therefore the board of directors' apparent interest in Monitor is not fully explained by the timing and circumstances surrounding the document data review. The reader will note that in Chapter Five the issue of Monitor's influence on the case studies is also highlighted by the interview data.

The final limitation is that the research assumes that the presence of key words in the documents is a proxy for the focus of board discussion. In certain instances, although discussions might not have used one of the key words, it might have been argued that the narrative could still be related to the search criteria. To counter this criticism the research methodology involved the researcher reading each of the board minutes at the time the document review was conducted. Although this approach could be argued to make the interpretation of the documents, and the board's focus, increasingly dependent on the researcher's judgement and therefore more subjective varying from researcher to researcher in its interpretation, it could increase the accuracy of the documentary review. It was therefore concluded that in this case the use of defined search terms, combined with the researcher reading each of the documents, provided the most robust research methodology.

4.6 SUMMARY RESULTS

4.6.1 Documentary Data

The objective of the documentary review above was to identify the degree to which the boards of directors of the four case studies had focussed upon productivity issues and identify any changes in emphasis over time. In addition, the review hoped that an indication of possible drivers for NHS productivity would be identified.

The reader will recall that, as the thesis is addressing the issue of the impact of PbR on productivity, PbR was one of the key terms searched in the board documents. Direct board focus upon the term PbR was very low in one case study, CC. In nearly two years of board meeting minutes it was only mentioned occasionally (less than one in five meetings) yet this hospital remains financially very strong. For the other case studies PbR was mentioned in at least every other meeting with FTs AA and BB having the highest rate of occurrence. FT AA had only recently received authorisation from Monitor to be an FT and as so much of the approval process is based upon financial considerations this could explain the relatively high prominence of the subject.

Case study FT BB had the highest mention of PbR, with most of the emphasis being on the structure of the new tariff. It should be noted that the occurrences happened during a period when the FT was going through significant financial challenges.

The documents were also searched for tariff as a substitute for PbR as the phrases are interchangeably used. The results reinforced the initial finding that FT AA and FT BB received the most positive search results. Most of FT AA's discussion of tariff focussed around the viability of individual services, which is the emphasis of the Monitor application process. In the case of FT BB again the focus was on tariff at the time financial pressure was most evident.

There is therefore some evidence to suggest that boards of directors of FT's focus upon PbR and tariff at times of pressure. The pressure that tends to produce that result can be purely financial (i.e. a financial deterioration impacting upon the FT's financial risk rating and the regulator (Monitor) therefore requiring corrective action); alternatively, the pressure can be explicitly regulatory as a consequence of the application process to be an FT. The two case

studies with the lowest referral to either PbR or tariff had, at the time of the research, greatest distance from financial pressure and regulatory focus.

A second group of terms which was searched in the documents related directly to productivity. When productivity itself was searched in the minutes in a two-year period the boards of all four organisations used the term around once in every four meetings. However, it is not only the frequency of the term's use but the context in which it is used that is important. In particular, were the boards using the concept in a context that suggested the board was considering productivity as the balancing of inputs, process and outputs or was it merely a loose term which the board used to discuss reductions in cost? Certainly in case study BB, which was actively engaging clinicians in a financial recovery plan, productivity was being used in the context of operating a theatre and clinical pathway review. In the other case studies productivity appeared to be used in a more generic sense, often indicating a reduction in inputs (i.e.a traditional cost improvement programme).

As an FT board is required to run its hospital effectively and efficiently a mention of productivity in one in four board meetings indicates the concept of productivity was not a common concern of senior management and the boards of the four organisations at the time of the research. It is very interesting that even at the time of regulatory pressure, close to the time of application as an FT or under financial pressure, board discussion was not about productivity.

It could of course have been that, although the phrase productivity was not used, FT boards were still addressing the issue but using language that involved the ingredients of productivity but not the term itself. As productivity involves the maximising of output for a given amount of inputs several other phrases were searched: in particular, cost control, reduce costs, cost improvement programme or reference to the organisation's costs relative to other hospitals by reference to the RCI and financial balance. The results showed that FTs BB and DD did not mention cost control and CC very occasionally; cost improvement programmes were mentioned by case studies AA, BB and DD about once in every four or five meetings and CC not at all. None of the boards referred to their RCI in the two year period.

The term efficiency was also searched and was mentioned very little by FT DD and never by CC. FT BB mentioned efficiency in two of every three board meetings but that FT was under financial pressure.

The overall lack of frequency of these case study boards focussing on productivity and other phrases associated with the delivery of efficient care is a clear indication that neither the concept, nor the ingredients of productivity, were the normal language, and therefore business, of these case study boards at the time of this research. It could be argued of course that these hospitals were just financially too comfortable and therefore they did not need to focus upon productivity. Case study BB (which was under the greater financial pressure) appears to focus at least twice as often than case study CC on efficiency and a third more often on tariff and in the case of DD seven times as often on efficiency and nearly three times as often on tariff. This might indicate that a driver is required for board focus on productivity.

An interesting observation from the results is that although PbR or tariff seems to have been mentioned on a reasonably regular basis by each of the case study boards those boards do not then focus upon productivity and related issues to equal extent. Except in a few cases, boards do not appear to be linking PbR tariff to discussions of productivity and there is little evidence that tariff is driving discussion around productivity.

In one of the case studies, FT AA, the results were markedly different. FT AA mentioned cost control in 9 separate board meetings during the period, reduction in costs on average nearly every board meeting, cost improvement programme in 10 board meetings and efficiency 13 times in 9 separate board meetings.. In the case of FT AA, this language was not limited to the time surrounding the application to be an FT so direct regulatory pressure cannot be the only explanation, nor was the organisation in financial difficulty.

It therefore appears that although regulatory/ financial pressure may have a significant impact upon the focus by boards on productivity (and related matters), in the case of FT AA something else may also have been occurring. An observation by the researcher is that the strong, consistent leadership shown by FT AA's senior management team may have had a significant impact upon organisational focus. Senior management capability was not a focus of this research, but may have been relevant in the case of FT AA.

One of the search terms used in the document review was service line reporting (SLR). As explained previously this is the establishment of data and reporting systems in a hospital which allows the care and resource use of an individual patient to be tracked so that the hospital can record the services consumed by a patient, the average resource use of a procedure and ultimately understand how the hospital uses its resources. The traditional use of block contracts by purchasers (where a hospital received a guaranteed sum of money for delivering specified types of care to the community without limiting output) has traditionally not encouraged the dis-aggregation of costs in this way.

When the term SLR was searched in the board documents two hospitals produced a nil return. This was probably to be expected as the use of SLR was not common, and remains limited, in hospitals. FT CC mentioned the issue in a couple of instances, but this was simply that the chairman of the board had been to a presentation held by Monitor and it was thought SLR could be useful for the FT. In the case of FT AA SLR was being given some operational importance as it was raised in several board meetings in 2007.

Reviewing the collective results for FT AA the dynamic which probably occurred is that the board had shown a continued interest in its cost base throughout the period of the documentary review and the emergence of SLR in the search results is as a consequence of the organisation being an early adopter of SLR operationally. It should be noted that SLR was brought to the attention of the FT sector by the regulator, Monitor, and was actively marketed by Monitor as a way forward for FTs. The research will mention the role and influence of Monitor in more detail shortly.

Although the research is indicating that financial pressure or regulatory influence may be having an impact upon the focus of boards on productivity there could be another issue. Is the composition and capability of boards critical to the productivity agenda? Boards, their chairs and their chief executives are responsible for setting the agenda and business of the board. If boards are not focussing upon the business critical elements of the hospital then the question must be raised about that board's competence. Through the approval process of becoming an FT the capacity and capability of boards is tested and those clearly not capable are invited to rebalance their membership. As FTs approach a time of increasing focus on health sector productivity perhaps this potential capability gap will become increasingly evident?

As FT CC and FT DD did not appear from the board minute review to be focussing upon the productivity agenda the research looked for other factors on which the boards of these organisations might have been focussed. As hospitals are delivering services then the quality of those services would be a key concern of any board, just as any commercial business would focus upon the quality of the services and products provided.

In a period of two years quality was a common focus of all four boards particularly FTs BB and CC with FT BB recording quality 33 times in its minutes. FT AA recorded quality half as often as FT BB and CC. As mentioned earlier FT AA had given significant focus upon the cost control agenda and it would appear from the documentary results that this might have reduced the board's focus upon quality. When FT AA mentioned quality in its minutes over the period about half of those entries referred to data quality as opposed to the actual quality of services. Data quality is particularly important with respect to recovering payment for activity under PbR. It is surprising that quality is not the dominant over-arching theme within the documentary review as Lord Darzi (a leading surgeon and former Minister of Health in the Labour government) was in the process of conducting his NHS Next Stage Review. Darzi's final report was laid before Parliament in June 2008 and there was a great deal of NHS engagement with the Darzi work during the period of this documentary review .

FT DD did not show evidence of a strong focus upon the productivity agenda and did not appear to have a major focus upon quality either with only [12] references to the quality of service in that period and [one third] of those references referred to the regulatory view of quality as opposed to inward discussions about the quality of services the hospital provided.

FT CC showed a greater focus upon the quality agenda with a large majority of the board meetings referring to quality and nearly two thirds of these references to quality were orientated directly to the quality of services as opposed to the quality of coding or staff training.

An interesting finding from the document review is that the board with the greatest focus upon quality, as recorded in the minutes, was FT BB with 33 references to quality mixed between quality of patient services, quality of activity coding and managing the need for cost control and productivity improvement while maintaining the quality of services provided. It would appear from the documentary review that, of all the four boards, FT BB demonstrated the ability to drive both the productivity and quality agendas. An interesting question is

whether this was because of the simple capability of the constituent members of that board (perhaps an opportunity for further research) or the application of outside pressure from the regulator driving board performance and focus.

Subject to the note of caution in 4.5 (Limitations of Document Review) what became clear during the course of the research was the impact that the regulator, Monitor, was having on the FTs within the study, particularly at board level. As part of the documentary review Monitor was therefore recorded as a search term in the minutes producing fascinating results. Bearing in mind that the search of quality (a key objective of the NHS) had produced an exceptionally high comparative score of 33 for FT BB, Monitor as a search result was 55 for FT BB, 44 for FT CC and 27 for FT AA. FT DD only had [11] references but FT DD board minute review is scoring low on a series of the key search terms. This issue is discussed later.

From the documentary review it is very clear that Monitor is consuming significant focus of the four FT boards in this study. It may of course be that, as Monitor is the regulator, boards are merely being careful in their recording of issues relating to Monitor as a method of protecting board members from any accusation of negligence should Monitor ever consider using its section 52 powers of intervention in the FT. Although this may partly explain Monitor's prevalence in the board minutes of the FTs, the types of things recorded (such as the Chairman had lunch with the head of the regulator or the Chairman attended a conference on SLR hosted by Monitor) suggests a more prevailing influence of the regulator with FT boards.

The influence of Monitor on the agenda of FT boards is discussed later when we review and analyse the results from the interviews set out in Chapter Five. What is clear from those interviews is that Monitor has established clarity in its regulatory framework so that FT boards understand the rules under which they must operate and the consequences for boards for non-compliance with their terms of authorisation.

In trying to identify what, if anything, was encouraging boards to focus upon productivity the documents were also searched for patient choice, choice and competition. Competition was not mentioned at all in three of the four case studies. It is surprising that this was the case given that two of the case study trusts were in the London area (which has a large number of providers) and that competition between those providers was likely to be more of an issue than in more rural areas. The practical application of competition is reflected in-patient

choice and choice as a concept. When choice and patient choice were searched the results were still very low. The highest prevalence of patient choice was actually for FT CC, which was a rural FT with limited competition from local providers. This case study mentioned the issue in respect of gearing itself up for choice, in particular information for patients and the impact of the choice process on patients themselves. The discussion was not in connection with the driving of productivity or quality. At the time of this research, with the choice agenda being in its early stages of implementation, there appeared to be no evidence that competition or choice was driving board focus or driving the productivity and quality of outputs agenda.

As the above analysis suggests that the boards of directors of the four case studies did not appear to be heavily engaged in the productivity agenda it is worth noting what the boards of directors of the four case studies did focus their time upon. When the researcher reviewed the board minutes of the case studies three key themes emerged. Firstly, a large amount of subjects discussed could be described as governance/administrative in nature. This category includes the approval of standing orders, risk policies, receiving and approving reports, and for FTs, the board of directors' relationship with (and accountabilities to) the members and council of governors of the organisation.

The second element, on which a significant amount of board focus occurs, is the recording of the delivery of operational targets. For instance during the period of the document review the NHS was committed to delivering the eighteen week referral to treatment target of ninety percent for admitted patients. As politicians considered the delivery of this target to be critical for the NHS, significant time was being spent by boards of directors ensuring its delivery. The delivery of this, and other access related targets, was to a large extent moving organisations away from discussing productivity. Anecdotal evidence suggests large amounts of NHS resource were being used to increase speed of access with limited focus on added output for that cost.

The third, and final, area of focus in the case study minutes is around strategy. Focus in the minutes covered both developing the strategy itself (FTs are expected to develop medium term clinical and financial strategies looking at least five years ahead which are annually refreshed) and the board receiving information as to changes in the national and local political and commissioning landscape which influence those strategies.

The above observations raise the question as to whether boards of directors of FTs are focusing sufficient time on the correct issues.

4.7 CONCLUSION

The results of the analysis of the document search results in 4.6 above are combined with the results of the analysis of the interview and productivity data in the form of a case study analysis in Chapter 7.

As previously mentioned the results from the documentary review were used in formulating the semi-structured interviews which were conducted with a selection of key staff of all four case study sites in the period September to December 2007. The following chapter looks in detail at the purpose, methodology and results from those interviews.

CHAPTER FIVE

INTERVIEWS

"Death will be a great relief. No more interviews."

Katharine Hepburn

5.1 PURPOSE

As set out in Chapter Two, the research is using three distinct methods of data collection in order to triangulate results. Chapter Four set out the documentary review. In this chapter we look at the interview data and in Chapter Six we consider the productivity data.

The interviews, which were conducted in the latter stages of 2007 and early 2008, aimed to produce qualitative data on the determinants of quality, quantity and productivity changes in the case study FTs. The interviews tested and built upon the results of the documentary review set out in the previous chapter. As the aim of this research is to obtain strong triangulation in the research results, reliance purely on documentary data was not appropriate and therefore this additional, and potentially rich, method of data collection was required.

As discussed in Chapter Two in deciding to use interviews as part of the research methodology the researcher has been mindful of the challenge that other research methods should be eliminated as an option, before interviews are adopted as a method, as most researchers believe they have the skills to interview (Bechhofer and Paterson 2000). The research objective is not only to identify what has happened, but also how and why it has happened and the research is explanatory in nature. The research question is also contemporary as most of the key players in delivery of the Plan are still either in post or accessible. For these reasons the use of case studies, based upon a small number of quality interviews, was an appropriate method of data collection (Yin 2003).

The objective of the interviews was to produce both descriptive information, concerning decision making on such issues as rationalisation of health production processes (productivity improvement), and also to provide explanations as to why, or why not, these

changes occurred. The interviews also allowed further investigation of the issues which emerged from the document review, for example the influence of the regulator.

5.2 METHOD

5.2.1 Design Issues

The design of the interview stage of the research needed to address two key issues: reliability (i.e. the consistency of the research findings) and validity (did the interviews measure what the researcher thought he was measuring (Kerlinger1979). The development of the interview guide, the trialling of the interview technique prior to interviewing the respondents and the systematic review of the interview transcripts focussed upon maximising validity and reliability.

5.2.2 Interview Respondents

As noted in the methodology chapter there are no simple academic criteria that can be applied for selecting the interview respondents but Bauer and Gaskell (2000) note that an individual researcher can probably cope with 15-25 individual interviews. The lower end of this range was chosen due to the interview data only forming part of the data collection and the seniority of the respondent would by necessity restrict numbers due to limitations on access. The time consuming nature of the interview process and transcription supported this decision.

The criterion used to choose respondents was to identify individuals who would provide high quality detailed data, effectively intensity sampling and again as Bauer and Gaskell (2000) noted

"*The real purpose of qualitative research is not counting opinions or people but rather exploring the range of opinions*".

For this reason the research attempted to identify both key supporters and opponents of changes within each of the case studies for interview. In particular, each of the case studies were requested to identify a sub-board level respondent for interview who was less convinced about the positive consequences of the introduction of PbR.

In order that the interviews could provide an effective insight into the drivers of productivity improvement in the case study FTs it was necessary to identify the group that could provide an effective overview of both internal, external and political factors. As the influence of PbR was likely to operate on those at a senior operational or board level in the organisation it was concluded that the target group for interview would be board members, senior clinicians delivering the service within a financial envelope and senior operational managers.

Since the research was focussing upon the impact of PbR on the alignment of clinical and managerial incentives it was necessary to have a combination of professional managers and clinicians in the interview cohort. At board level the key operational managers are the chief executive, chief operating officer, director of finance, director of nursing and the medical director. It was important that the directors chosen had a good understanding of the day-to-day pressures and forces operating within the relevant FT.

As noted earlier, the finance director has a pivotal role in ensuring the FT is financially viable and operating within the rules of PbR. It was therefore considered appropriate that the finance director should be interviewed. In particular, the finance director would be in a position to assess the degree to which PbR had an impact upon resource decisions (including capital and service developments), contract negotiations, and the need for cost improvement programmes.

It was also essential that a director with an overview of the activities of clinical teams was part of the respondent group. Two options existed: the director of nursing and the medical director. As the medical profession continue to have an overwhelming influence on clinical practice and decision-making it was considered that the medical director would have the greatest insight into issues of incentive alignment of clinicians. In addition, the post of director of nursing is increasingly adopting general management functions and it can be argued with increasing conviction that the nursing director is becoming a general manager rather than a clinically orientated nursing specialist.

The third person the research identified for interview was to be a senior manager with a day-to-day overview of the operations of the hospital in a key area. As the orthopaedics department is often under significant operational pressure, and therefore a focus for process

improvement, the general manager for orthopaedics, or a director with significant exposure to the dynamics of the orthopaedics department, was interviewed,

As noted earlier the researcher also considered the possibility of interviewing the chief executive of each of the case studies as they would have an over-arching perspective about productivity, quality and incentives. It was felt that the possibility of obtaining access to the chief executive was at best a remote possibility and so this avenue was not pursued. However, in two of the four case studies the chief executives made themselves available for interview which provided some useful perspective which the original methodology did not envisage.

In order to obtain an insight into clinical-managerial incentive alignment at an operational level access was also requested, and granted, to a leading consultant who was not necessarily as supportive of PbR to provide a potential counter view as to incentives, productivity and the impact of PbR. This was to assess the extent to which the views of the board were consistent with those at a more operational level. Anecdotal evidence also suggested that the perceptions of boards and more operational managers and clinicians can vary.

5.2.3 Access to Respondents

From the outset of the research the key risk to the project was an inability to secure access to the prospective respondents in the chosen case studies. In order to secure access to the FTs the Director of Strategy at Monitor was initially approached to elicit support for the project and if possible assist in identifying appropriate case studies and obtain direct support for access. After the initial meeting between the researcher and the Director of Strategy there followed a more detailed discussion with one of Monitor's two policy directors.

After the researcher identified the preferred case study sites Monitor's policy director was kind enough to contact the relevant FTs identified and a formal letter followed this initial contact from the researcher's supervisor to the chief executives of the four trusts requesting formal access. In two cases the researcher was given access to the cases studies immediately and in the remaining two case studies the researcher followed up the letter with a telephone call with the chief executives.

Access was given to all four sites and the chief executive's office in each case study provided contact details for each of the nominated participants. Due to the seniority of the individuals

concerned access needed to be planned several months in advance and in many cases it was not possible to have several interviews on one day due to diary clashes. Given the geographical spread of the case studies travel proved a significant time cost for the project.

5.2.4 Interview Form

As discussed in Chapter Two several options for interview structure were available. For the reader's convenience a brief summary of the options and decisions made by the researcher are set out below but for a fuller analysis please see Chapter Two.

Four main types of interview were available to the interviewer, structured, semi-structured, unstructured and informal interviews. These could be individual or group and the method of conducting the interview could be in person, by telephone, video link or web based.

As the interview questions were exploring underlying motives and behaviour the most effective method of interview was thought to be individual and face-to-face, in order fully to engage the participants in the project and to develop personal relationships so as to maximise the willingness of the respondents to disclose issues around incentives and drivers. If follow-up questions or clarification were required then it was envisaged that this could be dealt with by use of e-mail/telephone. Given the seniority of the individuals involved it was important that all issues could be effectively dealt with at the interview; subsequent access was likely to be difficult.

Video conferencing was considered as a method of reducing travel and other costs related to the research but due to the very limited access to this within FTs this approach was considered an unrealistic option and was therefore discounted.

With regard to the form of the interview the researcher considered the semi-structured/unstructured interview (unlike a structured interview which has defined questions with a narrow range of possible responses) which potentially allowed an in-depth understanding to be obtained which in the case of identifying consultant and manager incentives was important. For this reason the structured interview was discounted because of its lack of flexibility and depth.

The unstructured interview was considered as this would have potentially allowed a wide breadth of perspectives and opinions to be collected from each of the respondents, highlighting issues which the researcher might not have considered. The drawback with the unstructured approach was that the researcher would not have been able to cover the material required in the time permitted as access to each respondent had been limited to one hour. For this reason the unstructured interview was discounted.

The need for the interviews to be efficient yet flexible therefore led to the choice of the semi-structured interview which enabled the development of an interview guide so that all interviews could cover the core areas of investigation yet allow the interviewer to develop the questioning as the interview progressed in order to explore issues which emerged during the meeting.

With regard to conducting group or individual interviews the study used individual meetings. Although a broader number of respondents could have been potentially captured by use of the group interview (potentially using interactive information technology software to capture group responses) the objective of obtaining in depth analysis on incentives (and depth of understanding) and disclosure would not be enhanced by group interview. In addition, as mentioned earlier the respondents were high value individuals with time critical schedules and therefore the need to work around individual diaries made group interviews impracticable.

5.2.5 Interview Guide

The interview guide set out in Appendix 5 aimed to ensure that the questions were open ended, neutral, sensitive and clear (Patton,2002, as stated in Holloway, 2005).

Three main factors influenced the content of the questions in the interview guide. Firstly, the research question and the key hypotheses provided the main structure (for example the extent to which PbR influenced the organisation, clinicians and managers); secondly the results of the documentary review indicated areas that should be investigated further (for instance, the lack of discussion of quality at board meetings) and finally the practical experience of the researcher sitting on NHS boards indicated areas to test (for instance, the impact on board focus when going through an FT application. For example question 4 of the interview guide

asked **in the transition to FT did you perceive any change in focus? For instance, patient focus, governance structures, cost control**?).

The central research question (mentioned above), **whether the introduction of PbR into the NHS aligned clinical and managerial incentives improving output quality, quantity and productivity,** led to three subsidiary research questions which the researcher used to develop the interview guide.

The first subsidiary research question asked, **what is meant by NHS output and how had the NHS routinely measured outputs of NHS organisations?** Questions 5,6,14,15,23 and 24 of the interview guide focused on this issue. For example, question **5 asked how does the organisation measure its output (quantity and quality)?**

The second research question raised the issue of what was meant by clinical and managerial incentives and whether historically there had been a difference between the two groups and their incentives. This was addressed by questions 10,12,13,17,18,19 and 21. For instance, question 12 asked the respondent **how would you summarise the objectives of clinicians in this organisation? Has this changed over the last three years?**

Finally (assuming that the incentives of clinicians and managers were different), questions 4,7,9,11,16,20 and 25 of the interview guide explored whether the introduction of PbR contributed to the alignment of those managerial and clinical incentives. For instance, question 25 asked respondents, **in which areas did they think productivity had increased most within the organisation and what had been the key to this success (if any)?**

The five remaining questions addressed two issues. Questions 2 and 3 aimed to put the respondent at ease and provide a background context to the interview by introducing a very open question; for example question 3 asked respondents **where would you say the organisation had focused its main managerial energy since becoming an FT? For instance quality, design, efficiency?**

The final group of questions 8, 22 and 27 provided opportunities for the respondent to identify alternative drivers to PbR which had produced productivity improvement in the organisation. For instance, question 22 asked whether respondents **considered regulators to have had any impact on the organisation, and if so, how?** This question was included as

the document search had identified regulators (particularly Monitor) as a major focus of FT boards of directors at their meetings.

As Hansen (2006) suggests the interview guide was trialled, prior to formal use, on a limited number of participants before the main interview programme was commenced. Initially trialing the questions on a non-specialist respondent tested the interview guide to remove weaknesses in the style and meaning of the questions. Following this initial test the interview guide was adapted including introducing question 2 as a non-challenging introductory question, which was factually based so as to put the respondent at ease. The type and breadth of the questions covered were then tested on a serving NHS finance director at a strategic health authority in the south of England.

As a consequence of the above process the researcher produced the interview guide set out in Appendix 5 which was used in all the interviews.

5.2.6 Data Collection and Analysis

The interviews were conducted on site at the relevant case study FT and were scheduled for approximately one hour (the interview guide indicates 69 minutes) but this was adjusted according to the respondent's time availability and the level of engagement with the project of the relevant respondent.

All the respondents appeared to be very open and willing to disclose their personal perspective on the research questions on the condition that the data obtained from the interviews, and their responses, were anonymised. With the consent of each of the respondents the interviews were recorded and the researcher undertook to destroy the recordings and transcripts at the end of the research project.

The interview process went well and most of the interviews completed around the one-hour point. In one case the respondent was keen to develop his arguments and therefore this interview lasted over the sixty-nine minutes indicated in the interview guide. Due to work pressures of another respondent the interview was reduced to 50 minutes, but the material was effectively covered.

In many cases respondents did not need to be asked all the specific questions in the Interview Guide as they naturally flowed on to another question area when answering a previous

question. This allowed the researcher time to probe in more detail the particularly interesting answers provided by respondents.

At the end of the interview process, in early 2008, the recordings were then transcribed. This process turned out to be much more time consuming than the researcher initially contemplated. An example of an extract from an anonymised transcribed interview is attached at Appendix 3.

The researcher then systematically reviewed each of the transcribed interviews and a summary of the respondents' views, against each of the questions, was recorded. An example of an extract from an anonymised interview response table is set out at Appendix 4, which relates to the extract from the anonymised transcript at Appendix 3. The production of the interview response table is an attempt to make the results of the interviews as sensitive as possible, given the high value nature of the respondents, in line with Kvale (1996).

Each transcript was subjected to two reviews. Firstly, the responses to each question were summarised in the response column next to the relevant question. The transcript was then subjected to a second review to identify answers which had strayed from the specific question asked but provided information relevant to another area. The responses from all the interviews were then grouped into broad themes, which are set out below and summarised in the results table, Table 5.1. For ease of reference the questions, and question numbers, in the results table are identical to those in the Interview Guide at Appendix 5.

The outline of the interview responses below are anonymised. The four case studies are identified as Case Study AA, BB, CC and DD and relate to the case study coding established in Chapter Two and continued in Chapters Four and Six. If relevant, the responses of various groups are highlighted and variations between case studies identified. When helpful to highlight a result a direct quote from the interviewee is identified

5.3 RESULTS

The narrative below identifies the key results from the interviews which is followed by a high level summary in Table 5.1 below. The narrative and Table 5.1 relate to questions 3 onwards of the Interview Guide. Responses to questions 1 and 2 have been omitted as they

were designed as introductory questions to settle the respondent rather than forming part of the data collection.

The results from question 3, **as to where the case studies had focussed their managerial energy over the last three years**, were in common agreement that the achievement of national targets, mostly related to access, and the delivery of their financial plans dominated their organisation's agenda.

An interesting result was that case study BB, which was financially challenged, used the clinical quality agenda to drive a productivity programme. A manager of BB observed " *that I think we moved our eye off the ball……. we were very much focussed on the growth and expansion of services because the money was coming in*" but hospital BB used a review of clinical pathways to promote patient quality as the method to ensure that processes were not wasteful of resources. A six per cent reduction in inputs was achieved within a twelve month period. The FT sector in general is expecting to deliver these levels of cost reduction in 2011-12 and it will be interesting to see if necessity is the mother of innovation.

Two other case studies, AA and DD, noted that, having achieved access and finance targets, they were then able to focus more on the real clinical quality agenda, rather than the proxy of access. One director of DD noting that the system had had a clear set of levers to deliver the proxy quality targets (for instance accident and emergency access times) namely "*they [regulators] basically beat us round the head if we're missing a target and that's how it is driven*". There is a clear implication that access and finance targets were distractions from the quality agendas of the hospitals concerned.

On the issue of transition to FT status (question 4) respondents from all four case studies noted that changes to governance structures, as a consequence of the FT application, had also absorbed significant management focus. It was also felt that the FT transition significantly reinforced the importance of financial control. The medical director of BB observed;

"*in order to become an FT you have to satisfy a lot of hoops and getting through those hoops makes you look really hard at the money and the productivity as a consequence* "

A senior clinician at AA commented;

"*I have seen a change in the management, it is now much more financial orientated – it always was to some extent, but the impression I get is that it's much more money orientated now – they're much more interested in that than perhaps the clinical side – I just sense that"*.

It is interesting to note that several high profile governance failures in hospitals within England over recent years have put the achievement of access and financial targets as contributory factors to those failures; the clinical failures at The Mid Staffordshire NHS Foundation Trust are an example (Francis 2009).

Question 5 focussed upon the issue of measuring clinical quality. All four case studies (including respondents from clinical and managerial groups) noted that the organisation reviewed clinical data. When discussed in more detail it became evident that all the case studies routinely reviewed proxies for quality (for instance access measures) and case study DD reviewed quarterly mortality data but none of the case study respondents indicated that there was any systematic measurement of value added to patients (for instance SF36 measures of patient functionality pre- and post- clinical intervention). As a respondent from case study DD, noted measuring value added is " *an area where we're pretty poor in having systems to measure outcomes beyond the immediate and also outcomes that are beyond the ad hoc audit*". This sentiment was reinforced by a clinician at AA who noted that he was not aware of any systemised added value measures for quality but noted that management:

"*seem to rely on us to have an overall picture of what the quality is like because there are none of my consultants who are particularly poor surgeons or anything like that, [who] I have any concerns about – we'd soon get to know*"

The recent development of patient reported outcome measures by the DoH may go some way to bridging this output measurement gap particularly if the measures are extended to a larger number of treatments.

On the question of whether the measurement of quality had changed over the past three years, all the case studies indicated that there was a movement to collating patient views as opposed to the traditional provider centric measurement of quality. For example, one respondent from case study BB noted the introduction of a patient quality tracker (which focused upon six key questions of patient experience) was intended to put patient views at the forefront of decisions of organisational change.

Question 7, **has the introduction of PbR had a material impact on costs, efficiency or quality within the organisation**, was a key response for the research. There was a clear distinction between two respondent groups. Respondents at board level were in agreement with the general position outlined by the Finance Director of BB who considered PbR provided the backdrop to many of the operational decisions made within the organisation. It provided the context for all decision making or as the finance director of AA commented;

"*Well, put it another way. What PbR has done is it has provided a financial context, because prior to that price equals cost so there was no real incentive to become more efficient. So because it creates winners and losers it creates a sort of competitive aspect – that has driven focus on efficiency and productivity".*

At a more operational level a senior manager at CC considered that PbR's impact on costs etc could be summarised as '*In terms of reality, no*" impact. The Finance Director of AA agreed with BB's Finance Director that whole services could be financially judged due to the financial back-drop of PbR but also noted;

"*I know that it [PbR] is intended by the Government to help drive clinical efficiency because it should make clear any differentials if you like. But the classification will not deliver that, it doesn't deliver it and if you're going to have a genuine debate with your clinicians over relative effectiveness then you have to do that at the patient level".*

PbR was, in most cases, therefore not impacting upon operational behaviour. Several respondents felt that rather than PbR delivering quality and efficiency improvement progress was more attributable to national targets. For instance, one manager noted " *I wouldn't say it's PbR driven I would say it's general performance driven*".

In line with the response to question 7, when respondents were asked about **whether PbR had caused an alignment of incentives between clinical and managerial staff** (question 20) respondents indicated the impact was limited. Apart from certain departmental-specific pilot schemes for SLR, respondents considered that clinicians and operational managers had not yet been routinely exposed to PbR tariff and costs data and therefore PbR was not really having an impact on behaviour. Budgets were often still being allocated upon an historical cost basis. Exceptions to this view were in specialties where clinicians and managers wished to develop a service (one example being cardiology) and had to prove the specialty's financial viability in order to expand its services. In this case clinicians and managers had used PbR to support the case for service development. As a director of DD noted with respect to clinical understanding of tariff and costs *"cardiologists would be able to tell you down to the penny, the general physicians would not – they wouldn't know where to begin."*

This differentiation of views between Board and sub-board respondents as to the impact of PbR is reinforced by the responses to question 9 below.

One of the most interesting (and initially unexpected) results from the research was the response to question 8. This question asked **what other factors apart from PbR had an impact upon costs, efficiency and quality?** A common theme in all four case studies was the influence of the FT regulator, Monitor. As a director of DD noted with regard to Monitor's impact "*The setting [by Monitor] of criteria for your financial risk rating has had a profound impact on our budget strategy* " and goes on to note that the delivery of surpluses by the Trust has probably been higher because of Monitor's financial rating system. One of the chief executives noted "*the financial matrix that they've [Monitor] brought in and the clarity of thinking around that I think has assisted the Board"*

Also of interest was that the impact of Monitor was noted by respondents at an operational level within the case studies. A respondent at CC noted that the regulator "*created pressure for improvement*". While an observation from a senior operational manager at BB who was

involved in the hospital's financial recovery observed with regard to the delivery of the programme:

" *was that Monitor or was it because we had to do it? I'd argue that we had to do it - Monitor was the kind of bully boys to make sure it was delivered"*

Question 22 specifically asked the question **as to whether regulators had an impact on the organisations**. At board level the responses indicated that Monitor had a significant impact on board focus. As one chief executive noted "*the benefit of Monitor is clarity of focus….reducing the fudge within the NHS, I think*". Respondents below board level were conscious of the over-arching influence of Monitor on the organisation but it had a less direct impact upon them.

Linked to the influence of Monitor is the introduction of service line reporting (SLR) which combines income, cost and potentially quality reporting within one system. The adoption of this management approach has been actively pressed by Monitor by means of 'seed funding' of ten pilot sites, publicity and adoption of SLR now being a key requirement for any FT which finds itself in breach of its terms of authorisation as an FT. A director of BB noted that organisations needed to introduce SLR to procedure level as " *it's only at procedure level you start to unravel good and bad clinical practice*" thus allowing clinical teams to drive the productivity agenda. The potential of SLR to drive productivity improvement was mentioned by respondents in all the case studies. At the time of the research the practical role out of SLR to operational level was very restricted with one respondent noting;

"What we're only just beginning to get our heads around is managing income and expenditure in a way that's slightly more 'real world ".

Question 9, **which asked what was the level of clinical understanding, and engagement, with PbR**, produced a very negative result as to PbR's direct influence on clinicians. The respondents of all the case studies, both clinical and managerial, were in agreement and as

the medical director of DD noted " *most clinicians have a very hazy idea*" of PbR and the medical director of BB observed that;

"*anaesthetists will have no understanding at all because it doesn't impact on them……..they are a cost, an essential cost, they are our largest consultant group they are also quite hard to drive in terms productivity*".

An operational manager at CC noted " *it doesn't hit their [clinical] radar really*". and a manager at AA observed " *a very broad spectrum of them would say, no idea, no idea what that HRG [tariff under PbR] is*". It was interesting that a leading clinician at BB observed;

"*the more we get to know about PbR the more you realise there's a very strange Alice in Wonderland aspect to it that makes it [PbR] lose credibility*".

The latter point probably relates to the unpredictable changes in tariff from one year to another. Or, as the chief executive of one of the case studies noted with respect to PbR;

"*I think [what] people in general find quite hard is the variability of the tariff year-to-year and quite what to make of that in relation to the costs to the organisation*".

The responses to this question strongly indicates that PbR may not be having an impact on agendas and therefore managerial and clinical incentives to drive productivity.

Although question 9 had indicated a low engagement with PbR by clinicians, Question 11 **attempted to identify any characteristics which tended to pre-dispose a clinician to an interest in the concept, be it age, gender or specialism**. The only thread that appeared to have any common theme was that those that have an interest do so '*because they want to change something…..there is a general interest in formulating their business strategies and*

developing their services' . But at the time of the research this had only resulted in sporadic engagement by clinicians with PbR.

In order for clinicians to be focussed on PbR, and therefore allow PbR to stimulate engagement and alignment of incentives between managers and clinicians, a driver for clinicians to be interested in PbR is required. A traditional management model in hospitals is for clinical directorates to be managed on a tripartite basis between a lead nurse, clinical director and a general manager as envisaged in the Grey Book in 1972. Question 10 was therefore aimed at identifying the extent to which clinicians took effective responsibility for delivering their services within a prescribed budget. Question 10 asked, **do clinicians have responsibility for delivering their service to a budget within this organisation. Has this changed over time?**

All the case studies indicated that there was a difference between theoretical clinical accountability for budgets and the reality. In all the case studies it appeared that the general managers and the clinical directors agreed the budget (and in some cases clinical directors formally signed-off that budget) and in theory worked to operating within the budget. The finance director of AA being quite clear that;

"we [the executive directors] would expect it to be a partnership between the clinical director and the general manager and they're held accountable in the monthly budgetary control meeting".

But in practice the accountability for operating within a budget appeared to rest with the general managers with the clinical director's accountability being theoretical rather than actual. One general manager was very clear that ultimately the clinical director could step down from the role in management and still have a respected professional career as a clinician; general managers on the other hand are dependent on good performance for their next role and are therefore subject to effective performance levers and therefore accountable.

With respect to whether there was a variation in the objectives of clinicians and managers there was a common view across all the sites that clinicians had a patient care focus as would be expected. But, within this, respondents commented that their clinical reputation amongst

their peers was a key factor as was the promotion and development of their own specialism within the hospital. The medical director of CC noted;

"*most people [referring to consultants] are driven and put in a very high level of work and what drives the majority – and I would say well over 90% - is a desire to improve their department and to improve their service, they genuinely want to do that*".

Another medical director noted that there was "*nowhere to go*" in terms of career progression for consultants, which was unlike the position for the junior managers with which they worked.

With respect to managers there was a belief by clinicians and managers themselves that to do the demanding role there had to be an underlying altruistic motivation to provide good quality health services. However, both groups then saw one of the major motivations of managers as being to deliver the operational targets, both to ensure career progression and by implication some degree of financial reward. The chief executive of DD noted about managers;

"*I think there's something about keeping your head above water which isn't there to the same extent with the clinicians, and that's the level of the process of attrition that some of the management have, either been through or are going through which distinguishes them*".

The contrast in motivations might reflect itself in a tendency for clinicians to be internally focussed on their specific clinical areas, perhaps promoting the interests of their specialism, whilst managers might naturally have a more corporate performance and systems orientation.

When asked about **what issues do clinicians and managers engage most upon. Has this changed in the last three years** (question 21)? The most common response was where service developments were under consideration or on issues such as infection control. A director of DD noting that managerial and clinical co-operation " *works brilliantly [on] service development, and we can move the service forward, and it can be fantastic*". This

response appears to indicate that collaboration is mostly possible on the areas which clinicians value, rather than on the performance agenda which appears to be a key focus of management.

Questions 14,15,16, 17 and 19 dealt with the issue of quality within the case studies. Definitions of what quality of care meant varied widely between respondents. Many of the responses focussed upon safety and compliance with core process standards such as access times. In a few instances, quality was considered from a patient's perspective, but this appeared to be theoretical rather than the hospital systematically measuring patient reported outcome measures. As the medical director of one case study noted "*meeting targets has become a surrogate for quality of care***"** and a senior manager of case study DD responded;

"*It's an area where we're pretty poor in having systems to measure outcomes beyond the immediate and also outcomes that are beyond the ad hoc audit*".

With the exception of one chief executive who noted "*I would say most clinicians would say the quality of care here has improved since we became an FT*" respondents across organisations generally considered that quality had not materially risen in recent years. Some respondents thought quality of services had declined while a respondent in the same organisation as the chief executive above reflected "*I think it (quality) has stayed about the same*". Respondents did not generally equate service quality with speed of access. There was general consensus that the whole board was responsible for the quality of services, although unsurprisingly, the medical directors and the directors of nursing were initially highlighted. Managers were considered by all the respondents to be engaged with the quality agenda, but, when pressed, respondents seemed to indicate, as the previous medical director suggested, that quality was synonomous with targets and that reliable quality data, such as re-admission rates within thirty days, was difficult to obtain in some cases. A senior doctor at BB noting;

"*And that's the trouble with the information you're presented with, it's so crude it just means that you need to look into it deeper to get the information that you really want and the quality of information that we can get is extremely poor – we really struggle with it".*

Questions 18,23,24 and 25 explored respondents understanding of the productivity agenda in the case studies. Given the current focus of the NHS on productivity improvement the results are of particular interest. All the respondents were clear as to what productivity meant to them and the common theme was that it involved close scrutiny of inputs and improvement in the process of care to maximise output. But a doctor from BB noted that if you asked most other people in the organisation what they understand by productivity they would probably respond "*what are you on about?"*

When asked whether their organisations were focussed on productivity the responses were mixed. Case study BB, which had been under financial pressure, had addressed the productivity in a systematic way, a doctor noting;

"*The idea was to make changes that would be embedded into the organisation, that would be sustainable, rather than making short-term cuts that couldn't be sustained for another year. The idea was to try and make efficiency gains*".

Many respondents in the other case studies indicated that some work on pathway re-design had occurred in some specialities but the approach was not systemised and most of the focus was on traditional annual cost improvement programmes instead of dealing with more radical pathway re-design.

There was no clear theme when respondents were asked to identify the department that they thought had showed most improvement in productivity except that departments that were perceived as making progress tended to be those who had faced a financial need to address costs due to sustainability issues or needed to produce a business case to support expansion. Departments varied from orthopaedics and cardiology to specialisms such as sexual health.

In contrast, in case study BB, which, as the outlier case study, was required to take radical action to remedy an underlying financial problem, a leading clinician noted;

"*we made an awful lot of really good quality gains in length of stay by taking out all kinds of inefficiencies and improving process".*

In that particular instance the hospital had introduced a clinically led transformation programme which had addressed some of the core business processes of the hospital and delivered significant productivity improvement. This is reflected in the productivity data in Chapter Six.

The above results are summarised in Table 5.1 below. The numbers in the left hand column of the Table correspond to the question numbers in the Interview Guide. As indicated, the numbering commences at question 3 as the introductory questions have been omitted.

Table 5.1

Interview Results Table

No	Main Questions	Summary of Results
3.	Where would you say the organisation has focused its main managerial energy since becoming an FT? For instance quality, design, efficiency?	Respondents considered hospitals to be target focused (financial and Health Care Commission). The financially challenged FT focused on financial balance using clinical pathway reviews to link the finance and quality agendas. The more established FTs were starting to focus more on real clinical quality rather than achieving access targets as a proxy for quality.
4.	In the transition to FT did you perceive any change in focus? For instance, patient focus, governance structures, cost	A general view that the financial focus of organisations was further emphasised.

	control?	
5.	How does the organisation measure its output (quantity and quality)?	Output measures generally viewed as national access targets and Monitor financial reporting. No real evidence that value added clinical data was measured. Limited evidence that Boards reviewed actual clinical outcome data.
6.	In your experience, do you think there has been any change in how outputs are measured in the last three years, and if so, how and why?	General focus was considered to be on access targets. But more established FTs starting to consider patient satisfaction data.
7.	In your opinion has the introduction of PbR had a material impact on costs, efficiency or quality within this organisation?	General view that PbR had not had a direct impact within the organisations, but respondents with a whole systems view considered PbR created a context in which development and other decisions now operated. One respondent, from an early FT applicant, considered that most strategic decisions now operated within the context of PbR and that tariff actually distorted some decision-making e.g hospitals being paid less for patients staying less time discouraged some projects that could reduce length of stay.
8.	What other main factors do you think have had an impact on costs, efficiency and quality within this period and how important where they relative to	There was a common view that the regulatory framework (especially Monitor's financial orientation) and national access targets forced Trusts to look at costs and process.

	PbR?	
9.	What is the level of clinical understanding and engagement with PbR?	General view was that clinical understanding of PbR was limited but with exceptions. Organisations that have had to deal with financial challenges appeared to have greater understanding and there was a general view that surgeons with private practice (familiar with operating in fee for service environment) were more familiar with PbR than specialties such as medicine.
10.	Do clinicians have responsibility for delivering their service to a budget within this organisation? Has this changed over time?	Clinical ownership of budgets at specialty level seemed limited. Some indications that clinical directors had responsibility for delivery of service within budget but in final analysis general managers were responsible for delivery. Even in the most established FT there was no evidence that clinicians or managers understood the cost of delivering individual services. Many respondents indicated the trialing of Service Line Reporting (which was being undertaken in several FTs) provided an opportunity to move financial and productivity issues down to clinician level.
11.	Which kinds of personalities are most engaged with PbR within the organisation?	No real gender or age profile indicated. Most common view was that clinicians with private practice or clinicians with a specialty that faced a financial challenge (i.e. operating above tariff) and wanted to

		expand were most engaged.
12.	How would you characterise the objectives of clinicians in this organisation? Has this changed over the last three years?	Clinical reputation amongst peers, minimisation of risk and patient care were the most common themes.
13.	What are the objectives of managers in this organisation. Has this changed over the last three years?	Themes identified were: career progression (which meant delivery of financial and other targets); a degree of public service altruism and financial motivation.
14.	What do you understand by quality of service?	No standardized view. Mixture of safety, compliance with minimum process standards (e.g. access) and some respondents mentioned adding value to patients. No evidence that measures existed on the latter point.
15.	What has happened to clinical quality in the organisation in the last three years?	Mixed responses. No respondent suggested material improvement organisation wide. Mixture of views around slight deterioration (because of financial pressure) to static.
16.	If a change in quality has occurred what do you think have been the drivers of that change?	HCC targets and benchmarking commonly mentioned as drivers for improvement. Improvement in internal clinical governance also indicated in some cases.
17.	Who is responsible for the quality of care in this organisation? Has this changed over the last five years?	Initial response commonly the Director of Nursing supported by the Medical Director on key areas. This was often followed by the Board as a whole. No real changes over time were identified.

18.	Who is responsible for the efficient delivery of care in this organisation? Has this always been the case? If not what has changed?	Common response was that it was a common corporate responsibility. Within that general position it appeared that management effectively owned the efficiency agenda as opposed to clinicians.
19.	How engaged are managers in the agenda around quality of care in this organization? Has this changed over the last five years? If yes, what is the driver of this change?	General response was that managers were engaged in the clinical quality agenda. When pressed clinical quality appeared synonymous with delivery of targets and their appeared to be limited quality data widely available. Some respondents indicated that acquiring reliable quality data was problematic. For instance, basic data around re-admission rates within 30 days of treatment sometimes not available.
20.	Has the introduction of PbR had any impact upon clinical/managerial behaviour for instance cost, planning, and quality focus?	Respondents indicated that PbR had had limited impact within the FTs themselves as clinicians, and managers had not been subjected to reliable data concerning tariff and costs. Most budgets were still allocated on an historical basis. Impact of PbR appeared to have been limited to specific specialties that had had to engage with PbR to ensure delivery of sustainable service as clearly out of line with tariff or had been part of a pilot scheme.
21.	On what issues do clinicians and managers engage most upon? Has this changed in the last three years?	Respondents noted infection control indicators and service development, as the most common areas.

22.	Do you consider regulators to have had any impact on the organisation and if so how?	General view was that Monitor has had material impact on the organisations. In particular, reviewing governance systems and ensuring more rigorous financial control. The robust compliance regime forced two of the FTs to impose tough cost reduction/productivity programmes.
23.	What does the organisation understand by productivity and does your view differ in any respect?	Respondents often viewed productivity as controlling inputs and improving hospital processes to maximise output. It was often thought that those in the organisation saw productivity more as a cost cutting process to stay solvent.
24.	To what extent is productivity a focus of the organisation? For instance, within the board, divisions and clinical teams.	Mixed response. Very clear that the word productivity used but within the organisations several respondents considered that the real care pathway re-design work (which was required to improve productivity) did not occur. Practical implementation was therefore a traditional cost reduction programme.
25.	In which areas do you think productivity has increased most within the organisation and what has been the key to this success (if any)?	No common thread. Most common examples tended to be surgical specialties (e.g. orthopaedics) or an area which had been under financial pressure and had therefore completed a review of its business through necessity.
26.	Is there anything we have not discussed which has driven productivity in this organisation?	Responses nil or emphasis of a point already mentioned.

5.4 LIMITATIONS OF METHODOLOGY

This section sets out some of the key limitations of the interview methods applied in the research.

5.4.1 Reliability and Validity

A key risk with any interview is the reliability of the research technique. In particular the researcher has conducted all the interviews, listened to all the tapes and compiled all the transcription and data analysis. In a larger, formally funded, research project a selection of the tapes and data analysis could have been checked by another researcher to ensure reliability. Resources did not allow that in this case.

The researcher has attempted to minimise reliability concerns by development of a robust interview guide (Appendix 5), interview response and data review sheets (Appendix 4) and implementation of trial interviews prior to commencing the research (5.2.5 above). The trialling of the interviews also assisted in checking validity of the interview guide.

As indicated in 5.2.2 above the respondent group included the medical director and a second medically qualified respondent, to reflect the clinical perspective on PbR and incentive alignment. Although the reasons for using medically qualified staff as a proxy for the clinical perspective remain valid, a larger piece of research without tight resource constraints might include other clinical staff in the respondent group. For instance, access to a senior matron in each case study to obtain the nursing perspective and the ability to interview a larger number of respondents would contribute to improved research validity.

Internal political bias is a potential problem for the interview element of the research. Senior management teams within the NHS work in a very political environment and there can be a tendency to ensure that a consistent, politically acceptable, message is presented. It is hoped that the confidential nature of the interviews has, to a large extent, minimised that risk. The apparent willingness of respondents fully to engage with the research suggests this limitation is minimal

5.4.2 Generalisability

As the interview element of the research was only based upon sixteen interviews in four case study sites the research cannot claim statistical generalisability. The respondents to the interviews were not chosen at random and no probability coefficients reflecting statistical confidence levels could be applied. This limit with regard to statistical generalisability does not restrict the findings with regard to analytical generalisability. It is quite legitimate to make a reasoned judgement based upon the findings in this research as to what might be the case in similar organisations (Kvale 1996). This analytical generalisability will be developed in Chapter Seven.

5.4.3 Data Recording

The richness of the data acquired from the respondents might have been improved if the non-verbal responses to the questions could have been accurately recorded and reflected upon in the analytical stage of the research; for instance, a video recording of the interviews. In particular, this might have given some extra data when issues of motivation where discussed with the respondents. On balance, as much of the data collection was of a factual nature, this limitation is not considered material and the resource implications of video recording would have been prohibitive.

5.5 SUMMARY RESULTS

5.5.1 Interview Data

In this section the interview results are analysed and in Chapter Seven those summary results are considered along with the productivity and documentary summary results in the form of a case study analysis

In response to the question as to where the case studies had focussed their managerial energy over the last three years respondents were in common agreement that the achievement of national targets, mostly related to access, and the delivery of their financial plans dominated their organisations' agendas. It is worth noting that the financial plans of FTs are created by the FT boards themselves and therefore it is unlikely an FT would set objectives (be they quality or productivity) which are too stretching; non-delivery of an FT's plan can lead to difficulties with the regulator, Monitor.

An interesting result was that case study FT BB, which was financially challenged, used the clinical quality agenda to drive a productivity programme. FT BB used a review of clinical pathways to promote patient quality as the method to ensure that processes were not wasteful of resources. A significant reduction in input costs was achieved within a twelve-month period. As noted earlier, the RCI did partially rebound after the initial reduction.

Two other case studies, FT AA and FT DD, noted that, having got access and finance under control, they were now able to focus more on the real clinical quality agenda rather than the proxy of access.

On the issue of transition to FT status respondents from all four case studies noted that changes to governance structures, as a consequence of the FT application, had also absorbed significant management focus. It was also felt that the FT transition significantly reinforced the importance of financial control.

The reader will recall from the interview data that there was a general respect for the clarity of the message that Monitor is delivering to FTs. The process which Monitor requires FTs to go through to attain FT status appears to be changing the mindset of organisations requiring effective board level governance and financial discipline. This raises the question of whether this approach could be extended to promote change and improvement of quality and productivity. Perhaps more detailed conditions could be added to the licence requiring productivity and quality improvement to be demonstrated.

In terms of measuring clinical quality all four case studies (including respondents from clinical and managerial groups) noted that the organisation reviewed clinical data. When discussed in more detail it became evident that all the case studies routinely reviewed proxies for quality (for instance access measures) and case study FT DD reviewed quarterly mortality data. None of the case study respondents indicated that there was systematic measurement of value added to patients (for instance SF36 measures of patient functionality pre and post clinical intervention). It is interesting to note that neither the regulator, nor the DoH, required hospitals to understand the value added by the treatment they delivered and there appeared to be no aspiration by the respondents to do so.

On the question of whether the measurement of quality had changed over the past three years all the case studies indicated that there was a movement to collating patient views as opposed to the traditional provider-centric measurement of quality. For example, one respondent from

case study BB noted the introduction of a patient quality tracker (which focused upon six key questions of patient experience) and was intended to put patient views at the forefront of decisions about organisational change.

With regard to the key question as to whether the introduction of PbR had a material impact on costs, efficiency or quality within the organisation, there was a clear distinction between two respondent groups. Respondents at board level were in agreement with the general position that PbR set the context in which the FTs operated and therefore impacted significantly upon decision-making around costs, quality and efficiency. At a more operational level PbR was considered to be something that did not touch day-to-day decisions.

The theme that PbR did not appear to touch those in the operational roles within the organisation, including clinicians and many operational managers, was replicated when respondents were asked about the degree of clinical understanding and engagement with PbR, The general consensus was that PbR was not really understood or engaged with by many clinicians. In such circumstances, it is questionable as to whether it could act as a lever for change at operational level. If PbR is not engaged with by those who have the power to transform clinical pathways, or who are spending the clinical resources used on patients on a daily basis, then changes in packages of care are unlikely to occur despite any inefficiency identified by management. A key question arises as to why PbR and costs data was not focussed upon at an operational level. Was this reluctance related to a lack of confidence by senior management in the data, a lack of IT packages to make the data accessible to operational leaders or a lack of engagement at an operational level with the information? The answer is probably all three. A recent Kings Fund report on service line reporting indicates that clinical engagement at operational level with SLR/SLM (and by implication PbR which underpins SLR) is best achieved when clinicians are involved in both developing the reporting system and encouraged to dispute and engage with the data at an early stage (Foot, Sonola, Maybin and Naylor 2012).

With regard to a very open question as to what other factors, apart from PbR, may have had an impact upon costs, efficiency and quality, a common theme (in all four case studies) was the influence of the FT regulator, Monitor. The general view was that the way Monitor

regulated, with clarity and robustness, making the rules clear and demonstrating its willingness to intervene when necessary, made the regulator very influential.

Also of interest was that the impact of Monitor was noted by respondents at an operational, as well as board level, within the case studies, being characterised as a force for improvement. An interesting question arises as to why this pressure for improvement is felt so much when the boards of the organisations themselves should be generating organisational stretch. A key assumption of a decentralized NHS is that FT boards will have the capability to operate without standards and objectives being set by the DoH.

Linked to the influence of Monitor is the introduction of service line reporting (SLR)/ management. The adoption of this management approach has been actively pressed by Monitor by means of "seed funding" of several pilot sites and a large amount of promotion and publicity within the FT sector. The potential of SLR to drive productivity improvement was mentioned by respondents in all the case studies.

5.5.2 Emerging Issues

The interview data produced several interesting themes, which although they may not directly contribute to this research, are of interest and may require further investigation. Firstly although clinicians and managers were both considered to show altruistic behaviour towards patients - wishing to maximise the quality of patient care (possibly even knightly behaviour as the commitment was often perceived as going far beyond contractual requirements (Le Grand 2003)) - key objectives of clinicians also included promotion of their own clinical reputation and development of their own specialties within the hospital. This supports the proposition at 1.3 that if PbR was to be engaged with by clinicians then the knavish (Le Grand 2003) desire to promote their own specialty within the hospital, and their personal reputation within it, should be supported. Of wider interest though is how the NHS might incentivise its clinicians to be more productive in terms of reward schemes. For instance, rather than trying to use financial incentives to promote excellence (for instance merit awards for consultants) should the NHS be supporting high performing clinicians to secure peer recognition by academic publication, articles in journals and other profile based support? This might be more effective in supporting clinicians' desire for peer recognition.

The second point of interest is in respect of indicators for measuring the quality of care. Over recent years there has been significant focus upon the introduction of quality measures that look at the value added to patients from clinical interventions. Devlin and Appleby (2010) noted that patient reported outcome measures (PROMS) have been routinely available in the NHS since 2009 and that there is an intention to expand those measures to diseases other than hip and knee surgery, hernia repair, varicose veins and cataract to mental health, cancer care and long term conditions such as stroke and heart failure. It was therefore very interesting to note that none of the case studies were using either national PROMS data or locally developed PROMS information to assess the quality of the services the FTs were providing. In addition, no desire was expressed to pursue this kind of reporting either by clinicians or managers. In times of financial constraint in the public sector it is increasingly important that public funds are spent in a way that adds most value to patients and if PROMS are to be used by the NHS to ensure services maximise value then clinicians and managers will need to engage with the data effectively. Further research might look at why clinicians and managers appear not to be engaging with the concept of PROMS and what NHS leaders might need to do to support further engagement with the concept of PROMS and the use of that data in reviewing quality within hospitals.

The third area of interest was that although clinicians at clinical director level (i.e. the clinician responsible for running a particular service alongside the general manager) were notionally jointly responsible with the manager for the performance of the service, both clinicians and managers were of the view that should the service they manage fail to perform clinicians could always return to clinical practice, but the manager could not. As a consequence, the manager was often the individual who was effectively held accountable for performance. If this dynamic is correct then it would be interesting to understand what impact this has on the ability of senior leaders effectively to manage clinical services particularly when clinical engagement is required concerning decisions around clinical practice and service change. Perhaps a topic for further research.

5.6 CONCLUSION

The results from the interviews indicate that the delivery of financial and other targets dominated the agendas of each of the case studies with suggestions that only when delivery of the basic targets was achieved could hospitals focus on the quality of care agenda

(although one hospital did appear to use the clinical quality agenda to actually deliver financial and other targets). The results also indicate that the process of becoming an FT had the effect of focussing the organisations on financial delivery which, everything else being equal, might suggest less focus upon other issues.

With respect to clinical quality there was a general acceptance that the case studies did not systematically measure clinical outcomes, such as patient reported outcome measures, and that most of the time the hospitals were performance managing proxy quality measures such as access times to treatment.

With respect to whether PbR had an impact upon quality, output and productivity the results indicate that from day-to-day PbR did not drive operational decisions but PbR did provide the context in which boards, in each of the case studies, made strategic decisions. For instance, services tended to be expanded in situations when PbR tariff was above the costs of delivering the service. There was little evidence, though, that clinicians were focussing on productivity and efficiency issues as a result of their awareness of PbR tariffs and the financial viability of their services. This is an interesting result, given that unconfirmed indications suggest that the NHS Operating Framework for 2012-13 may permit commissioners and providers to move away from PbR based contracts, allowing them to revert to 'block' contracts. In their simplest form, block contracts allow commissioners to pay a provider a fixed fee for the delivery of all specified clinical services to a given population. As one of the key elements of PbR is to allow price (tariff) to drive productivity improvement in service providers it may be that the perceived failure of PbR to change clinical behaviour and drive productivity improvement is having a significant impact on national policy decision making.

A key, but unexpected result, from the interviews was the observation by respondents, particularly at board level, that Monitor had a significant impact on organisations as it established clarity on issues such as performance and created a pressure for improvement. In addition, Monitor's role in promoting SLR, which was seen as potentially promoting engagement of clinicians in the productivity agenda , indicates the regulator's influence; although at the time the interviews were conducted SLR was only just being introduced and respondents indicated that, at an operational level, it had only had an impact on clinical and

managerial behaviour in limited areas. These and other results are discussed further in Chapter Seven.

The next chapter introduces the proxy productivity data and identifies two proxy measures for productivity in the four cases studies and provides a high level overview of relative productivity in each hospital.

CHAPTER SIX

PRODUCTIVITY DATA

'When everything seems to be going against you, remember that the airplane takes off against the wind, not with it"

Henry Ford 1863-1947

6.1 INTRODUCTION

The previous two chapters have set out the results from the review of documentary and interview data respectively. This, the final data section, considers six indicators of productivity for each of the four case studies. This chapter is then followed by an analysis chapter, which brings together the documentary, interview and productivity data results.

The productivity data is based upon two information sets. Both sets of information are produced by the Department of Health (DoH). Within the limitations discussed below, the data has been subject to standardised collection and analysis. The first index which the research uses is the relative cost index (RCI) for NHS acute trusts. This data set is compiled annually and is the basis on which tariff, under PbR, has been historically set.

The second information set was produced by the Institute of Innovation and Improvement and was based upon NHS wide data on hospital length of stay, surgery day case rates and pre-operative bed days. The intention being to demonstrate to NHS providers that by reducing variation in clinical care pathways significant cash releasing productivity improvements could be achieved by NHS providers.

6.2 RCI DATA SET

6.2.1 Construction

The RCI effectively represents the average cost of producing different elements of clinical care for a hospital which is translated into a number showing whether that hospital's costs for

different types of care are above the national average, therefore making a loss, or are below the average therefore making a profit. The data for calculating the RCI is submitted by each NHS organisation for each HRG (i.e bundles of care consuming similar resources) to the DoH using established protocols set out in the NHS Costing Manual and Guidance. The data is then compiled into a National Schedule of Reference Costs for each trust in England by HRG, and, from this data set, the weighted average of all HRG costs in a trust, relative to the national average, is then compiled; this being the RCI. In addition, the average cost of producing each HRG across all English hospitals forms the basis of the tariff (payment) under PbR for each clinical treatment falling within a particular HRG. It is interesting to note that, as Dawson and Street (1998) observed, the policy assumption in collecting the RCI data in the first place was that trusts would view their relative position within the RCI index and this would create "incentives to change the way they use resources" i.e. promote productivity.

A trust's RCI therefore shows the average cost of delivering a basket of procedures and treatments in that trust relative to the average of all English NHS trusts. For instance, a trust with an RCI of 100 would be delivering its services at the average cost of delivering the basket of services within England. Consequently, as 100 represents the average cost of delivery an RCI of less than 100 would therefore indicate relatively efficient provision and those with an RCI of over 100 relatively inefficient services. Care should be taken with these conclusions, as set out in the limitations section below.

The RCI index is sub-divided for acute providers into several categories. In particular, the costs of delivering elective, non-elective inpatient, critical care etc are given their own RCI score. The trust-wide RCI is also recorded with, and without, a market forces factor (MFF) taken into account.

The MFF adjusts for the unavoidable cost differential of delivering the relevant services, under each HRG, in different parts of the country. For example, higher costs of maintaining the labour force, such as the provision of London weightings for staff in the capital, and additional costs associated with higher labour mobility in some parts of the country. As the case studies in this research are geographically spread across the South West and South East of England the MFF adjusted RCI figures are presented as the costs of labour and other inputs vary significantly across the regions.

In addition to the hospital's organization-wide RCI, the table also records the elective and

critical care RCI's. In the case of elective work the care pathway is capable of being standardised and therefore would lend itself to productivity improvement. Critical care is a relatively small department and should lend itself to service redesign should it be an area of high cost within the trust. These areas are therefore much more likely to be areas to achieve productivity improvement, as opposed to non-elective inpatient (in particular general medicine), where the co-morbidities of patients and reliance on other agencies for discharge (for example social services) complicate care pathway redesign.

In determining whether the RCI data for each FT is indicating an improvement in productivity it is the trend over the three-year period, which is relevant. This is especially the case given the limitations of this data discussed below. It should be noted that during the period of the data being reviewed there has been a 2.5% productivity assumption in the funding of the NHS. Under such conditions a majority of trusts should be improving their productivity. As the RCI is a relative index, an FT must be outperforming the average trust in productivity improvement in order to improve its RCI. Conversely a deteriorating RCI may not indicate productivity falls but may simply indicate productivity improvements below that of the average NHS trust.

Subject to the limitations set out in 6.2.3 below the advantages of using the RCI are that established protocols for the collection and submission of data exist (as described above), the index applies to all acute trusts in the NHS (therefore includes the four FT case studies in this research), and the data collection methodology has been subject to rigorous review by the Audit Commission, and consequently the DoH, adding to its accuracy.

6.2.2 RCI Data Results

The four tables below set out the RCI data for the four cases studies for the three financial years 2005-6, 2006-7 and 2007-8 followed by a brief description. The analysis of the results is dealt with in the following chapter.

Table 6.1-FT AA

Year	Organisation (MFF Adjusted)	Elective RCI	Critical Care RCI

	RCI		
2005-6	97	93	97
2006-7	98	108	96
2007-8	92	108	92

It would appear that FT AA (using the RCI measure) has improved productivity across the organisation as a whole, seeing the RCI fall from 97 in 2005-6 to 92 in 2007-8, although it increased very slightly in 2006-7. Similar improvements in the RCI have been achieved in Critical Care with a steady fall from 97 to 92 in the same three-year period.

Less positive is the increase in the hospital's RCI for elective work, which has risen substantially from an RCI of 93 in 2005-6 to 108 in 2006-7 and remained at this high level in 2007-8. Everything else being equal this suggests a significant deterioration in relative productivity in the FT's elective work.

Table 6.2 FT BB

Year	**Organisation (MFF Adjusted) RCI**	**Elective RCI**	**Critical Care RCI**
2005-6	98	122	98
2006-7	88	90	82
2007-8	97	93	93

The trend in FT BB's RCI is consistent on all three indicators. Between 2005-6 and 2006-7, when the FT imposed significant efficiency targets on the organisation, the hospital-wide RCI dropped from 98 to 88. This was reflected in an astonishing Elective RCI change of 122 to 90 and a large reduction in the Critical Care RCI of 98 to 82. But from 2006-7 to 2007-8 a material proportion of the reduction in RCI has been reversed. The organization-wide RCI

has reverted to 97, only 1 below its starting point in 2005-6, and the Critical Care RCI has risen to 93, although remaining significantly below its 2005-6 level of 98. Progress on Elective care appears to be more sustained with only a slight increase in the RCI to 93: still 29 points lower than it was in 2005-6. Overall FT BB appears to have delivered some relative productivity improvement.

Table 6.3 CC

Year	Organisation (MFF Adjusted) RCI	Elective RCI	Critical Care RCI
2005-6	93	85	104
2006-7	90	98	101
2007-8	97	86	125

FT CC provides very mixed results with respect to its RCI. Between 2005-6 and 2006-7 small declines in its RCI, and therefore improvements in productivity relative to other providers, were recorded for the organisation as a whole and Critical Care. In contrast, the Elective RCI rose significantly from 85 to 98 in the same period. In 2007-8 the FT recorded rises in its RCI across the organisation as a whole from 90 to 97 and in Critical Care from 101 to 125. Conversely, the Elective RCI reverted back to just above its 2005-6 level at 86.

If we look at the period 2005-2008 as a whole all three RCIs of the FT have increased indicating deterioration in relative productivity for the FT.

Table 6.4 DD

Year	Organisation (MFF Adjusted) RCI	Elective RCI	Critical Care RCI
2005-6	89	93	75
2006-7	82	87	71
2007-8	87	99	126

FT DD reduced its RCI for all three RCI indicators between 2005-6 and 2006-7. The organisation wide RCI declined from 89 to 82, the Elective RCI from 93 to 87 and the Critical Care RCI from an extremely low 75 to 71. All three indicators then witnessed significant increases in the year 2007-8 with the organization-wide RCI increasing to 87, the Elective RCI a substantial increase of 12 points to 99 and the Critical Care RCI from 71 to 126 representing a 55 unit increase. Although analysis of the results will be dealt with in the next chapter it should be noted that the increase in the RCI for Critical Care is thought to reflect an investment by the FT in an area of the Trust which had seen limited investment over previous years.

On the basis of the RCI data FT DD would appear not to have delivered improvement in relative productivity during the period as a whole.

6.2.3 RCI Data Set Limitations

Limitations as to data accuracy have been raised by the Audit Commission. In the Commission's review of £73 million worth of activity across all trusts in England they identified a coding error rate of 9.3 %. Most of these errors were attributable to poor documentation, lack of coding resource and low clinical engagement (Audit Commission 2008).

Data accuracy issues were also forecast by Dawson and Street (1998) due to what they perceived as a lack of automated data collection within trusts. For instance, no automated

systems for collection of resource use (such as diagnostics) which would lead to inaccuracy in counting units of activity, deficiencies in case mix measurement and variations in individual trust interpretation of the NHS Costing Manual and Guidelines. This is a position that has not materially improved.

The statistical significance of various forms of the RCI is discussed by Street (2000) who notes that if this efficiency score on its own is to be used as determining true differences in performance between hospitals then confidence intervals must be applied to the data. As one would expect, with the data collection issues raised above, when Street applied 95 percent confidence intervals to the data then variation between individual trusts in a given year was not statistically significant. Dawson, Goddard and Street (2001) confirm this view but note that the use of the index does offer useful insights into changes in performance of hospitals over time. For this reason the research does not make judgments about the relative efficiency of an FT case study compared to another organisation. The research uses the productivity metrics (discussed below) along with trends in the RCI of each of the FT case studies over time to determine whether, in each case study, any evidence existed of changes in relative productivity.

Care must also be taken in interpreting changes in the RCI index. For instance, an increase in the RCI may not indicate falling productivity. Efficiency from an NHS-wide perspective may be to move hospital-based activity from inpatient care to an outpatient community settings. The impact of this will be to reduce the number of units of activity (Spells) within the hospital and require the fixed costs associated with that activity, such as buildings and minimum clinical staffing, to be spread over a smaller number. The consequence for that hospital would be increased costs per unit of output and therefore reduced productivity. However, for the NHS as a whole, improved care (in an appropriate setting) at reduced cost may have been achieved.

6.3 PRODUCTIVITY METRICS

6.3.1 Construction

In identifying a second data set to indicate the degree of productivity improvement within the case studies the research required a more disaggregated data set than the RCI, which could

show, at a more operational level, whether productivity improvement was being achieved.

As productivity is a case of achieving optimum output by adjustment of inputs (for example bed usage) and care processes (for example, use of evidence based care bundles) good indicators to use would be data on the use of bed or labour inputs and an efficient care pathway while in hospital.

In September 2004 the Modernisation Agency launched the idea of *The Ten High Impact Changes* which it believed could improve the experience of patients by more appropriate care pathways, improve clinical outcomes and avoid unnecessary waste of resources. In short, the programme was aimed at improving NHS productivity. The impact of this campaign by the Modernisation Agency (part of the DoH) was that NHS management started to monitor key productivity variables. In particular, day surgery rates, length of stay and to a lesser extent patient admission prior to treatment.

Although productivity was not the NHS's political focus in the period 2005-8 (the quality agenda often dominating management time) the Institute of Innovation and Improvement (Institute) (the successor of the Modernisation Agency) continued to collect NHS-wide data on length of stay, surgery day case rates and pre-operative bed days. The Institute tried to demonstrate that achievable improvements in a specific variable could be translated into cash, releasing savings for individual NHS organisations amounting to several million pounds each.

Therefore the second data set used to identify improvements (or otherwise) in productivity comprised three indicators identified above as used by the Institute. The Institute started to record the metrics in the first quarter of 2006 and these are produced on a quarterly basis for each NHS trust. The methodology is therefore consistent and applied to all trusts in England, including the four FT case studies in this research.

It should be noted that the Institute also produces other metrics in addition to length of stay, day case surgery and pre-operative bed days such as do-not-attend appointments rates (DNA). Although these metrics could add to the richness of the productivity data they would be considered to be of a secondary nature and they were not part of the Institute's original battery of data collection. They have not therefore been included in the data set for this research, as for much of the period in question (financial years 2006-8) comparative data

would not have been available.

In order to illustrate a limitation of the productivity metrics selected the following tables also include re-admission rates (within 14 days) as proxies for quality as collected by the Institute. Because of the proxy nature of the metric, and the data availability only being from quarter one 2007/8, the data is only being used to illustrate a limitation of the analysis and is discussed further at 6.3.3.

The length of stay metric identifies the percentage of the hospitals bed days that could have been saved if the FT had reduced the excess bed days, above the average for England for the relevant HRG, by twenty five percent. Assuming there was no material variation in case mix across the case studies, in the case of FT AA by reducing its excess bed days by 25% it could reduce bed usage by 13.3% without any impact on output. Improved productivity would be indicated by this percentage falling over time.

The day case metric is very straight forward. The day case rate is the percentage of the 25 procedures identified in the Audit Commission's basket of day case procedures actually performed as day cases (Audit Commission 2001). Examples of day case procedures in the basket are extraction of cataract with/without implant and laparoscopy. Improved productivity would be indicated by increasing day case rates over time. In the case of FT AA day case rates increasing from the very low starting point of 63% of the basket of procedures.

The final metric is the percentage of all bed days in the hospital used for patients undergoing a procedure between date of admission and date of operation. For example, if a patient is admitted for an elective operation are they admitted the day before the operation (thus being a pre-operative bed day which might not be clinically necessary but administratively easier) or on the day of the treatment thus being more efficient. In the case of FT AA, everything else being equal, productivity would be improving if the 24.4% recorded in quarter one of 2006/7 declined over time.

6.3.2 Productivity Metrics Results

The trends in productivity, for each of the for the four case studies, are set out in the tables below. Below each table a narrative highlights the key results for each FT. Please note the national position of each trust is a score out of 176 NHS trusts in England.

Table 6.5 FT AA

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 1 2006/7				
National Position	139	139	94	NOT COLLLECTED
Indicator Score	13.4%	63.0%	24.4%	
Change Last Period	0.0%	0.0%	0.0%	

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 2 2006/7				
National Position	139	146	70	NOT COLLLECTED
Indicator Score	13.2%	59.4%	23.5%	
Change Last Period	-0.2%	-3.6%	-0.9%	

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days

Quarter 3 2006/7				
National Position	139	137	109	NOT COLLLECTED
Indicator Score	13.1%	63.1%	24.5%	
Change Last Period	-0.1%	+3.7%	+1.0%	

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 4 2006/7				
National Position	119	138	55	NOT COLLLECTED
Indicator Score	13.4%	63.4%	22.2%	
Change Last Period	+0.2%	+0.2%	-2.3%	

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 1 2007/8				
National Position	119	141	62	29

Indicator Score	13.3%	65.4%	22.5%	3.5%
Change Last Period	0.0%	+2.1%	+0.3%	0.0%

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 2 2007/8				
National Position	141	142	60	70
Indicator Score	13.7%	64.4%	22.5%	4.5%
Change Last Period	+0.4%	-1.0%	0.0%	+1.0%

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 3 2007/8				
National Position	157	157	121	102

Indicator Score	14.5%	57.1%	25.5%	4.8%
Change Last Period	+0.9%	-7.3%	+3.0%	+0.4%

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 4 2007/8				
National Position	148	156	98	73
Indicator Score	14.0%	63.0%	23.7%	4.4%
Change Last Period	-0.5%	+5.9%	-1.8%	-0.4%

The results of the productivity metrics for FT AA show that, with regard to length of stay, the percentage of bed days that could have been saved if the FT had reduced its excess bed days to the average (having corrected for age, sex and social deprivation) has actually increased from 13.4% in quarter one 2006/7 to 14.5 % in the third quarter of 2007/8, reducing to 14.0 % in the final quarter.

With regard to day case rates at FT AA these fell from 63.0% in the first quarter of 2006/7 to an extremely low rate of 57.1% in the third quarter of 2007/8 although this rate recovered to the starting value of 63.0% in the final quarter of that year.

FT AA did make some progress in terms of the percentage of beds used in pre-operative bed days starting the period with 24.4% of beds days being pre-operative and finishing quarter

four of 2007/8 at 23.7%. In quarter four of 2006/7 the hospital had achieved a level of 22.4% but this was not maintained.

The productivity metrics therefore indicate that overall FT AA has not made material progress in improving use of bed stock or maximising the efficiency of its care processes for elective work (as indicated by use of day case surgery). This supports the results in the RCI data at 6.2.2, which suggest elective care had not seen improvements in productivity but actual declines. This would be supported by declining use of day surgery and a deteriorating position on the length of stay indicator.

Table 6.6 FT BB

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 1 2006/7				
National Position	173	101	13	NOT COLLLECTED
Indicator Score	15.9%	69.3%	17.1%	
Change Last Period	0.0%	0.0%	0.0%	

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 2 2006/7				
National Position	N/A	N/A	N/A	NOT

Indicator Score	N/A	N/A	N/A	COLLLECTED
Change Last Period	N/A	N/A	N/A	

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 3 2006/7				
National Position	169	88	74	NOT COLLLECTED
Indicator Score	15.0%	71.1%	22.8%	
Change Last Period	N/A	N/A	N/A	

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 4 2006/7				
National Position	160	88	35	NOT

Indicator Score	15.7%	72.0%	20.9%	COLLLECTED
Change Last Period	+0.8%	+0.8%	-1.9%	

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 1 2007/8				
National Position	164	109	23	36
Indicator Score	15.5%	70.0%	18.7%	3.6%
Change Last Period	-0.3%	-1.9%	-2.2%	0.0%

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 2 2007/8				
National Position	155	145	40	55

Indicator Score	14.2%	62.4%	21.0%	4.3%
Change Last Period	-1.3%	-7.6%	+2.3%	+0.7%

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 3 2007/8				
National Position	158	110	16	22
Indicator Score	14.6%	69.6%	18.3%	3.7%
Change Last Period	+0.4%	+7.2%	-2.7%	-0.6%

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 4 2007/8				
National Position	135	134	43	41

Indicator Score	13.8%	67.7%	21.6%	3.9%
Change Last Period	-0.8%	-1.9%	+3.3%	+0.2%

Note

Accurate data was not available for FT BB in quarter two 2006/7.

The results for length of stay for FT BB, with regard to the percentage of bed days that could have been saved if the FT had reduced its excess bed days, show an improvement from 15.9% in quarter one 2006/7 (and one of the highest rates of NHS trusts being positioned 173 out of 176) to 13.8 % in the fourth quarter of 2007/8 (with an improved position of 135 out of 176).

With regard to the day case rate this declined over the period from 69.3% in quarter one 2006/7 to 67.7% in the final quarter of 2007/8. It should be noted that in several quarters FT BB achieved 70% or higher on this indicator but did not achieve sustained improvement.

In respect of the indicator for pre-operative bed days FT BB did not make improvements in productivity in this area. In the first quarter of 2006/7 its rate was a very low 17.1% (which reflected upper quartile performance compared with other NHS trusts) and therefore improvement was going to be a challenge. Apart from one quarter it remained a top quartile performer on this indicator throughout the two-year period.

The productivity metrics for FT BB indicate some progress but, apart from the length of stay indicator, the FT has not managed to sustain improved performance. In many ways this reflects the conclusion of the RCI analysis earlier where the FT registered significant reductions in its RCI only to be partially reversed the following year.

Table 6.7 FT CC

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 1 2006/7				
National Position	15	86	105	NOT COLLLECTED
Indicator Score	10.6%	71.0%	24.8%	
Change Last Period	0.0%	0.0%	0.0%	

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 2 2006/7				
National Position	10	107	102	NOT COLLLECTED
Indicator Score	10.4%	67.5%	24.7%	
Change Last Period	-0.2%	-3.5%	0.0%	

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days

Quarter 3 2006/7				
National Position	14	110	68	NOT COLLLECTED
Indicator Score	10.7%	67.3%	22.6%	
Change Last Period	+0.3%	-0.3%	-2.1%	

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 4 2006/7				
National Position	9	121	82	NOT COLLLECTED
Indicator Score	10.6%	67.0%	23.1%	
Change Last Period	-0.1%	-0.3%	+0.5%	

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 1 2007/8				
National Position	8	128	71	11
Indicator Score	10.3%	68.1%	22.9%	2.5%

Change Last Period	-0.2%	+1.2%	-0.2%	0.0%

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 2 2007/8				
National Position	11	78	62	17
Indicator Score	10.4%	73.0%	22.6%	3.2%
Change Last Period	0.0%	+4.9%	-0.3%	+0.8%

Indicator/Quarter	**Reduction in Length of Stay**	**Increase in day case rate**	**Reduction in Pre-operative Bed days**	**Emergency Re-admission within 14 days**
Quarter 3 2007/8				
National Position	6	81	76	15
Indicator Score	9.7%	73.7%	23.6%	3.2%
Change Last	-0.7%	+0.7%	+1.0%	0.0%

Period				

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 4 2007/8				
National Position	13	128	67	18
Indicator Score	11.1%	68.7%	22.5%	3.1%
Change Last Period	+1.3%	-5.0%	-1.1%	0.0%

FT CC started quarter one 2006/7 with a strong position with respect to other NHS trusts on the length of stay indicator ranking 15 out of 176 at 10.6%. This suggested that improvement would be challenging. In quarter three of 2007/8 it had improved this to 9.7%.

The FT also made progress on the pre-operative bed days indicator moving from 24.8% in quarter one 2006/7 to 22.5% in quarter four 2007/8 with each quarter being less than the first quarter.

On the day case indicator the FT was less consistent, starting quarter one 2006/7 with a day case rate of 71.0% against the basket, but this was not achieved again until quarter two 2007/8. FT CC finished the final quarter of 2007/8 at 68.7% a significant deterioration placing the FT at third quartile ranking compared with its peers.

It is worth noting that the day case rate was above 68% in all the quarters of 2007/8 and in two quarters over 73%. This, combined with strong performance on the other indicators (detailed above) may have contributed to the improvement in the Elective RCI in 2007/8.

Table 6.8 FT DD

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 1 2006/7				
National Position	145	31	174	NOT COLLLECTED
Indicator Score	13.6%	78.5%	32.0%	
Change Last Period	0.0%	0.0%	0.0%	

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 2 2006/7				
National Position	154	18	166	NOT COLLLECTED
Indicator Score	13.6%	77.9%	30.8%	
Change Last Period	0.0%	-0.6%	-1.3%	

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative	Emergency Re-admission within 14

			Bed days	days
Quarter 3 2006/7				
National Position	137	19	171	NOT COLLLECTED
Indicator Score	13.1%	78.7%	30.5%	
Change Last Period	-0.5%	+0.8%	-0.3%	

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 4 2006/7				
National Position	120	43	164	NOT COLLLECTED
Indicator Score	13.4%	77.2%	28.8%	
Change Last Period	+0.3%	-1.6%	-1.7%	

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative	Emergency Re-admission within 14

			Bed days	days
Quarter 1 2007/8				
National Position	158	56	137	77
Indicator Score	14.8%	76.5%	26.4%	4.1%
Change Last Period	+1.5%	-0.7%	-2.4%	0.0%

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 2 2007/8				
National Position	149	14	142	104
Indicator Score	14.0%	81.5%	26.0%	4.9%
Change Last Period	-0.8%	+5.0%	-0.5%	+0.8%

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative	Emergency Re-admission within 14

			Bed days	days
Quarter 3 2007/8				
National Position	141	39	125	104
Indicator Score	13.8%	78.8%	25.8%	4.9%
Change Last Period	-0.2%	-2.7%	-0.2%	0.0%

Indicator/Quarter	Reduction in Length of Stay	Increase in day case rate	Reduction in Pre-operative Bed days	Emergency Re-admission within 14 days
Quarter 4 2007/8				
National Position	166	14	123	108
Indicator Score	14.8%	83.3%	24.9%	4.7%
Change Last Period	+1.0%	+4.5%	-0.9%	-0.2%

FT DD showed improvement in the productivity metrics in the case of day case rates and pre-operative bed days, but showed deterioration with respect to the length of stay metric.

In respect of pre-operative bed days the percentage of bed days consumed between admission and operation accounted for 32.0% of bed usage in the first quartile of 2006/7, the highest of

our four case studies and making FT DD 174 out of 176 NHS trusts on this metric. The FT showed a steady and sustained improvement over each quarter resulting in a rate of 24.9% in the final quarter of 2007-8.

The day case rate recorded in quarter one of 2006/7 was a respectable 78.5% placing the trust as a top quartile performer and attaining 83.3% in the fourth quartile of 2007/8. Progress on this indicator of productivity improvement was less uniform with three of the eight quartiles showing deterioration in day case surgery to a low of 76.5% in the first quarter of 2007/8.

In respect of length of stay this metric showed improvement in 2006/7 but deterioration in 2007/8 indicating a lack of consistency. FT DD remained a lower quartile performer on this metric throughout the two year period ending quarter four 2007/8 with 14.8% of bed days that could have been saved if the FT had reduced its excess bed day usage.

It is likely that the deterioration in the length of stay metric and variation in the day surgery rate may be partial explanations for the deterioration in the FT's hospital wide and Elective RCI between 2006/7 and 2007/8.

6.3.3 Productivity Metrics Limitations

As with the RCI data set the limitations identified by the Audit Commission (2008) and Dawson and Street (1998) (as set out at 6.2.3 above) apply to the productivity metrics as much as they do to the RCI data set.

In addition, the productivity metrics used in this research have not taken into consideration improvements, or deterioration, in the quality of outcomes or care to patients as an indicator of changes in productivity.

The lack of real standardised quality indicators, such as post operative functionality tests (for example SF 36) or patient reported outcome measures (PROMs) currently being produced by the DoH for clinical procedures such as hip and knee replacements (Devlin and Appleby 2010) restricts the ability of the research to effectively take into account improvements in the quality of care. This is a clear limitation of this data set. As indicated earlier at 6.3.1, the above tables include re-admission rates (within 14 days) as proxies for quality as collected by the Institute. Because of the proxy nature of the metric, and the data availability only being from quarter one 2007/8, the data is only being used to illustrate the point.

On review of the re-admission rate for each of the FTs it will be noted that the emergency re-admission rates from quarter one 2007/8 to quarter four have increased in each case. For instance, FT CC records an increase in the rate of re-admission from 2.5% to 3.1% over the period: this might represent a 25% deterioration in quality. As any real conclusion as to improvement or deterioration in relative productivity must consider the quality of the outputs produced (in this instance the degree to which clinical procedures are being carried out fault free and therefore not requiring patient re-admission to correct clinical error) any data (such as that provided in this research) must be considered with some caution when concluding the degree to which productivity has varied in each of the case studies.

6.4 SUMMARY RESULTS

6.4.1 Productivity Data

The above results indicate a very mixed picture on productivity in the four case studies. The results from the review of changes in the organisation wide relative cost index (RCI) for the four FTs indicated that three of the four case studies saw a reduction in their RCI between 2005-6 and 2006-7 but in 2007-8 the RCIs of the three hospitals reverted to, or exceeded, their 2005-6 RCI. For instance, FT BB saw its RCI drop from 98 to 88 and then rebound to 97. A similar story occurred with FT DD. FT CC actually witnessed its RCI drop from 93 to 90 and then rise to 97 putting this FT in a worse average cost position relative to other hospitals than at the beginning of the study.

The exception to the above picture was FT AA which initially saw its RCI rise between 2005-6 and 2006-7 from 97 to 98 and then fall to 92. Even in this case the data did not indicate a consistent organisation-wide year on year improvement in relative productivity.

This inconsistent picture on productivity improvement was replicated when we considered the RCI of each case study with regard to its elective work. It should be noted that hospitals have the potential to have significantly more control over elective activity therefore permitting them to plan activity relative to capacity, standardise their care pathways to maximise patient safety, efficiency and ensure clinical effectiveness. This kind of environment would suggest easier wins with regard to productivity improvement as opposed to unplanned emergency care where demand can be much more variable.

The data for the Elective RCI for the four case studies indicated that FT AA saw a significant and sustained increase in this measure between 2005-6 and 2006-7 increasing from 93 to 108. This increase in its relative costs was then maintained in 2007-8. Two of the case studies saw their elective RCIs decrease between 2005-6 and 2006-7. FT BB witnessing its RCI drop significantly from 122 to 93 and FT DD from 93 to 87.

FT BB's change in elective RCI was probably a consequence of a cost improvement programme, which was implemented over a relatively short period. In both case studies the reduction in the Elective RCI bounced back. In the case of FT BB it reverted to 93 (still significantly below its starting point of 122) but FT DD witnessed its RCI rebound to 99 (above its starting point of 93). The final case study FT CC saw its Elective RCI rise from 85 to 98 between 2005-6 and 2006-7 but then fall again to 86; only marginally above its starting point and still not indicating an overall improvement or consistent trend in productivity.

The final RCI the research considered was the Critical Care RCI. Critical care usually represents a small part of the overall bed stock of a hospital (involving high dependency beds and intensive care facilities). These facilities are therefore expensive in resource and because of size (perhaps twenty or so beds in an average size district general hospital) should lend themselves to effective management; maximising quality and efficiency of care.

Three of the case studies witnessed initial decreases in their Critical Care RCI between 2005-6 and 2006-7, the most significant reduction being from 98 to 82 in FT BB. But in each of these cases a significant increase in each Critical Care RCI occurred between 2006-7 and 2007-8. FT BB witnessed a significant amount of its improvement being reversed, jumping back to 93, and the other two case studies seeing very large rises, FT CC rising from 101 to 125 and FT DD rising from 71 to 126. In contrast FT AA witnessed a decline in its Critical Care RCI year on year seeing it fall from 97 to 96 and finally to 92 in 2007-8.

It is clear from the RCI data, on all three measures, that none of the case studies had a sustained improvement in productivity in all three areas. On the basis of the RCI data the best record was shown by FT AA where two out of three measures showed improvement at the end of the period but even in that case study the Elective RCI witnessed a significant and sustained rise.

The research does not set out to explain the variations in the RCI over time but large variations in an RCI of up to 77 percent within a year (as in the case of FT DD in Critical

Care) need to be addressed for the integrity of the remaining data to be maintained. Investment in services, particularly critical care, usually involves significant investment in both facilities (causing a significant rise in depreciation costs for those services) and usually an increase in staffing. Both these investments can add significantly to the input costs of delivering a service and cause wide variation in a specialty's RCI. In the case of FT DD, a significant investment in critical care occurred but without proportionate throughput of activity, thus significantly increasing the Critical Care RCI. This investment in a service, everything else being equal, will indicate deterioration in productivity. Clearly this does not take into account any improvement in quality leading to increased patient survival and prognosis.

As mentioned above the results from the RCI data were supplemented by the productivity metrics produced by the Institute of Innovation, namely length of stay, day case rates and potential for the reduction in pre-operative bed days. There was also a review of emergency re-admission rates.

The productivity metrics results reinforce the conclusions from the RCI data. FT AA saw its excess bed days deteriorate from 13.4% in quarter 1 2006-7 to 14.5 % in the third quarter of 2007-8 and day case surgery rates also deteriorated from 63.0% in the first quarter 2006-7 to a low of 57.1% in the third quarter of 2007-8 only recovering to 63.0% by the final quarter of 2007-8. Limited improvement on the percentage of pre-operative bed days from 24.4% to 23.7% was achieved between the first quarter of 2006 and the final quarter of 2008. These productivity metrics do not indicate a trust making sustained headway on improving productivity within the organisation.

The productivity metrics results for FT BB also show an organisation not achieving sustained progress on productivity. In this case the results indicated a decline in the day case rate from 69.3% to 67.7% between quarter one of 2006-7 and the final quarter of 2007-8 (although several quarters showed higher performance) and the pre-operative bed days indicator deteriorated from a very competitive 17.1% to 21.6% in the final quarter of 2007-8. Although it could be argued that this indicator was unlikely to show a significant improvement due to FT DD already being a top quartile performer, in fact the metric deteriorated markedly over time. FT BB did show some improvement in the excess bed days indicator, moving from 15.9% in quarter one 2006-7 to 13.8% in the final quarter of 2007-8. This was an easy win

area for productivity improvement given its poor relative position. At the end of the two-year period it still remained a lower quartile performer on this measure.

FT CC and FT DD's productivity metrics showed a better productivity performance but still presented a mixed story. In the case of FT DD it exhibited an improvement in its day case rates and its pre-operative bed days. Pre-operative bed days showed a marked improvement dropping from 32.0% in the first quarter of 2006-7 to 24.9% in the final quarter of 2007-8. FT DD's day case rate also showed good improvement rising from 78.5% in the first quarter of 2006-7 to 83.3% in the final quarter of 2007-8. Unfortunately, FT DD's length of stay did not indicate the same success. This metric improved in 2006-7 from 13.6% to 13.4% in the final quarter of that year but throughout 2007-8 saw its performance significantly deteriorate ending the final quarter of 2007-8 at 14.8%

In respect of FT CC this case study also showed improvement in two productivity metrics. The length of stay indicator improved from a very good 10.6% in quarter one 2006-7 to 9.7% in quarter four of 2007-8. The hospital also showed consistent improvement over the two year period in its pre-operative bed days moving from 24.8% in quarter one 2006-7 to 22.5% in the final quarter of 2007-8. FT CC did not maintain its 71.0% day case rate achieved in quarter one 2006-7 and ended the final quarter of 2007-8 at 68.7%. Between this period it achieved a high of 73.7% and a low of 67%.

What does the research therefore conclude from a combination of the results from the RCI and productivity metrics with regard to productivity in the four case studies? All four case studies showed short-term variations in relative productivity but no sustained record of productivity improvement. There is some evidence to suggest that the hospitals tend to be able to make short-term changes in their relative cost base (for instance, FT BB saw its RCI drop from 98 to 88 on the back of a cost improvement programme) but then there is a tendency for organisations to revert to their traditional relative productivity position. For instance, BB's organisation wide RCI of 88 for 2006-7 rebounded to 97 within one year of the cost improvement programme being completed. The productivity metrics showed the same position with FTs showing short-term improvement in productivity metrics (for instance FT CC's day case rate showed significant variation over a two year period varying from 73.7% to as low as 67%). This does not suggest a reliable trend in productivity improvement. As discussed later this could be because action on productivity improvement

remains focussed on short term actions to reduce costs (which are not backed up by a fundamental review of operating processes), a failure by boards to address at a strategic level the issue of productivity and the way that the boards conduct their business (which could be an issue of board competence). A third explanation could be the non-engagement of clinicians in the productivity agenda thus not addressing the fundamental issue of reviewing and standardising care pathways to ensure quality of care and efficiency of care processes.

6.5 CONCLUSION

This chapter has set out the productivity data, identified the main trends and then conducted an analysis of the results for the four FT case studies. The next chapter brings together the findings and analysis from the documentary review, the interviews and the productivity data in a case study analysis. The case study analysis section is then followed by the final chapter which brings together the main conclusions of the research and considers the wider policy implications.

CHAPTER SEVEN

ANALYSIS OF RESULTS

"It requires a very unusual mind to undertake the analysis of the obvious"

Alfred North Whitehead

7.1. INTRODUCTION

In this chapter the themes of the documentary, interview and productivity data analysis in chapters four, five and six respectively are brought together and discussed in the context of the four case studies from which the data originated. The chapter will identify which issues were common across the case studies, and where variation occurs, why this might be the case. These results are then linked to the central and subsidiary research questions and the main conclusions from the results are explored. This section is then followed by the final chapter of the thesis, which considers the implications of the results firstly, in terms of implications for the management of hospitals in respect of delivering productivity and improving quality and quantity of output. Secondly, the wider implications the results might have for the Coalition Government's Health and Social Care Act 2012. The final chapter also explores opportunities for further research in the field.

7.2 CASE STUDIES

The four case studies were introduced in chapter two as case studies AA, CC and DD with an outlier case study BB. Key characteristics of the four case studies are set out below.

Table 7.1 Case Study AA

Geography/urbanisation	South East England, city location
Population	Serves a diverse socio-economic urban population of approximately 470,000 with a

	wider catchment for its specialist services
Provider Choice	Competing acute (general and specialist) providers within 5 mile radius
Authorisation	Authorised as a foundation trust in 2006
Financial Risk Rating	Financial Risk Rating of 4 out of 4 being the strongest risk rating for financial sustainability
Leadership	Long serving chief executive and stable executive management team
Clinical Engagement	No evidence of significant issues with clinical engagement within the organisation
Services	Combination of general acute services (including accident and emergency) for local population with some specialist services for example burns, HIV and paediatric and neonatal surgery

Table 7.2 Case Study BB

Geography/urbanisation	South East England, city location
Population	Serves a diverse ethnic minority urban population of approximately 250,000 a quarter of which is under 20 years of age with significant deprivation within the community.
Provider Choice	Competing acute (general and specialist) providers within 5 mile radius
Authorisation	Authorised as a foundation trust in 2004
Financial Risk Rating	Financial Risk Rating of 2 out of 4 being the

	strongest risk rating for financial sustainability and 1 being the weakest
Leadership	Long serving chief executive and stable executive management team
Clinical Engagement	Generally good clinical engagement, one of key factors indicated in contributing to delivery of a large cost improvement programme
Services	Combination of general acute and community services (including accident and emergency) for local population with some specialist services for example HIV

Table 7.3 Case Study CC

Geography/urbanisation	South West England, city location but covering a large rural population
Population	Serves a mainly white population of approximately 400,000 over a large sparsely populated rural area
Provider Choice	Nearest competing acute (general and specialist) provider 45 miles away therefore limited competition
Authorisation	Authorised as a foundation trust in 2004
Financial Risk Rating	Financial Risk Rating of 4 being the strongest risk rating for financial sustainability
Leadership	Long serving chief executive and stable

	executive management team
Clinical Engagement	Generally good clinical engagement
Services	Provides general acute services (including accident and emergency) together with some specialist services. For example, orthopaedic surgery, renal, plastic and thoracic services.

Table 7.4 Case Study DD

Geography/urbanisation	South East England urban/coastal location (not city)
Population	Serves a mainly urban population of approximately 550,000 but rises during summer months due to tourism.
Provider Choice	Competing acute provider within 10 mile radius
Authorisation	Authorised as a foundation trust in 2005
Financial Risk Rating	Financial Risk Rating of 4 out of 4 being the strongest risk rating for financial sustainability
Leadership	Long serving chief executive and stable executive management team
Clinical Engagement	No evidence of significant issues with clinical engagement within the organisation
Services	Combination of general acute services (including accident and emergency) for local population with some specialist services for example burns, HIV and paediatric and

	neonatal surgery

7.2.1 Common Factors Across Case Studies

As discussed in Chapter Two, and as indicated in the tables above, all four case studies had been authorised as FTs in the earlier waves of the transition from NHS Trusts to FTs between 2004-6. Due to the FT application process requiring boards of directors of applicants to demonstrate their organisation is managed in an 'effective, efficient and economic manner' all four case studies had been able to illustrate to the regulator high standards of performance and governance and that the organisations were effectively managed. The four case studies were therefore considered to be high performing organisations in the NHS context. As each of the case studies had been through this process in the last three years they had been subject to an external governance review led by Monitor and supported by leading firms of accountants (for example KPMG). This would mean that the hospitals had demonstrated that they had financial and management systems and processes which were fit for purpose and could manage the hospital effectively under the PbR regime. For the purposes of this research all four case studies would have the basic systems from which they could take advantage of any benefits accruing from PbR be they financial or operational.

The second common factor was that all the case studies were subject to the same accountability structures. As mentioned in Chapter Two, by ensuring all the hospitals were FTs the research removed the variation that might have been caused by the four case study hospitals being in different StHAs as the performance cultures across those StHAs could have varied significantly. As discussed in earlier chapters, as FTs all four case studies were subject to the same regulatory structure led by Monitor and therefore subject to the same performance and incentive regime. All four hospitals were also subject to the same internal accountability structures with respect to reporting to their governors for the performance of the hospital and delivery of each case study's strategy as set out in 3.5.1. The impact of working in the same regulatory and performance management environment is that all four case studies will have been subject to the same requirements and development opportunities (for instance encouragement by Monitor to implement SLR) when operating under the PbR regime. They would also have had the same potential to access support and information as to how best to

implement management and other systems which would allow the hospitals to maximise their effectiveness under the PbR .

The third common factor illustrated in the tables above is that all four FTs had stable and long serving management teams and no specific problems evident with respect to clinical enagagement. Chris Ham notes in the King's Fund's recent paper on reforming the NHS from within that one of the critical factors in successful delivery of change programmes is leadership continuity (Ham 2014). He cites Salford Royal Foundation Trust as an example of continuity of leadership leading to high performance and this is supported by the experience of hospitals such as Virginia Mason in Seattle, USA that has successfully introduced Lean methodology and has been supported by stable leadership over a fifteen year period. As all four case studies have continuity of leadership (combined with being high performing organisations) and no evidence of concerns with clinical engagement they should all have been well placed to take advantage of any opportunities that PbR provided to align managerial and clinical incentives and deliver improved output, quality, quantity and productivity.

The fourth common factor in all the case studies was the basic portfolio of services provided by each hospital. All four case studies delivered general acute services to their populations (including accident and emergency) and provided some specialist services. None of the hospitals had designations as regional trauma centres neither were they specialist hospitals. The only slight difference in services provided was that case study BB delivered some community based services (including nursing home facilities) but these were relatively small compared to its acute services. From the point of view of the research this means that all four case studies were of similar size (i.e. medium sized district general hospitals) and complexity of services. This indicates that in terms of implementing management systems to support the organisation in operating under the PbR regime, and developing managers and clinicians to operate within in it, senior management in each case study faced similar challenges in terms of size and complexity of organisation.

7.2.2 Differences Across Case Studies

There are two key areas were the case studies are subject to variation. Firstly, the geography and the populations of the case studies lead to an impact as to choice of provider for patients. Secondly, case study BB was chosen because it had a different financial status compared to the remaining three hospitals. These two differences are discussed below.

With respect to the population, geography and provider choice case studies AA and BB are in city locations serving concentrated populations and in both cases the hospitals are close in proximity to alternative providers. In both instances these alternative providers deliver the general and specialist services provided by each of the case studies and therefore patients have an effective choice of provider and consequently each of the case studies face potential competition. From the point of view of the research there is therefore potential for individual specialities within case studies AA and BB to be subject to competition for patients and therefore one might expect potential for clinicians and managers to engage with PbR in order to understand the sustainability of their services and maximise their efficiency. In addition, it might be expected that the board of directors of the case studies might consider competition a potential risk and this might have been highlighted in the documentary data.

With regard to case study DD, which although in an urban/coastal area also faces potential competition from a provider within five miles the same as case studies AA and BB we might expect similar responses. A slight difference in this case is that the competing provider to DD does not compete with FT DD's more specialist services and it does not therefore face the prospect of local competition across all its provision.

With respect to case study CC which has a mainly rural, very dispersed and ageing population where the nearest provider, for all its services, is 45 miles away competition is significantly restricted. In FT CC's case, it is likely that clinicians and managers will not perceive competition to be a threat to their speciality and therefore PbR, and the financial viability of their services might be considered less of a concern. This might also impact on the board of directors focus on PbR .

The second issue of variability was the financial status of the four case studies. As discussed in Chapter Two (and set out in Tables 7.1-7.4 above) FTs AA, CC and DD all had financial risk ratings of three or four and were therefore not of financial concern to Monitor at the time

of the research. FT BB, which had a risk rating of two was subject to regulatory review and therefore the sustainability of the hospital, and individual specialties within it, would have been the focus of general management and clinical leaders. Under such circumstances, particularly, where alternative providers existed to deliver the services (please see discussion above), it might be that PbR would be more likely to contribute to the alignment of managerial and clinical incentives and deliver improved output, quality, quantity and productivity.

7.2.3 Analysis Across Case Studies

The detailed analysis of the results was carried out in Chapters Four, Five and Six respectively. This section brings together the themes in that analysis by reviewing those themes across the case studies and then explaining any variation.

A consistent theme across all the case studies was that none of the hospitals had delivered sustained improvement in productivity, as indicated by the RCI or productivity metrics on a wide range of indicators, during the period of the study. In terms of organisation wide productivity improvement the two best performers were FT AA and FT BB. FT AA finished 2007-8 with an organisation wide RCI of 92 compared to 97 in 2005-6 and FT BB managed to reduce its RCI from 98 to 88 in 2006-7 (but this subsequently rebounded in 2007-8).

In explaining why FT AA and BB performed marginally better on the overall productivity metrics the data provides some possible explanations. In respect of FT AA it will be noted that it had recently completed the FT application process in 2006. The board minutes suggest that, as part of that process, the board of directors took a keen interest in understanding productivity related issues, particularly around tariff and the viability of individual services, which is the emphasis of the Monitor application process. FT AA was also a pilot site for SLR implementation which may have also contributed. This organisational focus might well have led to some improvement in overall productivity.

In the case of FT BB, although its productivity improvement was short lived, the change was the largest reduction of all the case studies over the period. As the reader will recall FT BB was the outlier case study that had a Monitor financial risk rating of 2. The impact of this was that the hospital was subject to close regulatory monitoring and this was reflected within the documentary and interview results. For instance, FT BB's board minutes recorded the

highest focus on PbR (particularly with respect to changes in tariff for its main services) of all the case studies. In addition, the interview data illustrated that FT BB was implementing a clinically driven improvement programme focussing on efficiency rather than a traditional cost improvement programme driven from the top down.

A common theme for all the case studies from the interview data and documentary review has been the significance of Monitor as an influencer of each of the hospitals. In all the case studies Monitor recorded the highest incidence of all the terms in the documentary review and Monitor's influence was highlighted by interview respondents across all the case studies both at board and operational level. Although all the case studies noted the influence of Monitor it was particularly pronounced in the cases of FTs AA and BB. This is probably due to FT AA having been through the FT application process during the period of the documentary review and FT BB being the subject of regulatory scrutiny due to its poor financial position.

In terms of the significance of PbR all the case studies produced a very similar response. At board level it was thought that PbR set the commercial rules in which the FTs operated. In that respect it impacted significantly upon decision-making around costs, quality and efficiency of services. At an operational level PbR was considered to be something that did not affect day-to-day decisions. With respect to clinical understanding and engagement with PbR the consensus was that PbR was not really understood, or engaged with, by many clinicians. It is not clear from the data whether PbR data has not been effectively shared with clinicians because management lacked confidence in the data, because of a lack of IT packages to make the data accessible to operational leaders or because of a lack of engagement at an operational level with the information by clinicians and managers.

Conversations around clinical quality occurred at the board meetings of all the case studies to varying degrees, and as we noted earlier FT BB recorded the highest incidence of PbR, efficiency and quality. This congruence is probably explained by the clinical transformation programme that was being followed at the time of the review. In terms of measuring clinical quality, all four case studies (including respondents from clinical and managerial groups) noted that the organisation reviewed clinical data. What is evident is that all the case studies routinely reviewed proxies for quality (for instance access measures) and FT DD reviewed quarterly mortality data. None of the case studies had significant programmes for the

measurement of value added to patients (for instance SF36 measures of patient functionality pre and post clinical intervention). It is interesting that regulators do not require hospitals to understand the value added to patients by the treatment they deliver and (as mentioned in Chapter Five) there appears to be no aspiration by the respondents to do so.

A very interesting result is that competition was not mentioned at all in three of the four case studies; this is especially interesting as FTs AA and BB are in city locations with potential competition within five miles (please see Tables 7.1 and 7.2 above). When the documentary search was widened to patient choice the incidence increased but remained relatively low. The interview data also failed to highlight competition as a major driver of focus on PbR or productivity improvement. Given that FTs AA, BB and DD were all in close proximity to other providers this is an interesting outcome. There is nothing in the results to explain the relatively low significance of competition as a focus of the four case studies. It may be that, when hospitals are attracting greater demand for their services than the capacity they have to deliver it, losing a few patients to competing providers might be rather helpful.

7.3 CENTRAL AND SUBSIDIARY RESEARCH QUESTIONS

7.3.1 Questions

The central research question of the thesis is whether the introduction of Payment By Results into the National Health Service has aligned clinical and managerial incentives and improved output, quality, quantity and productivity.

In order to fully answer this central question several subsidiary research questions needed to be addressed. Three of these subsidiary research questions were answered in the literature review. In particular:

7.3.1.1 what is traditionally meant by productivity and how has the NHS routinely measured inputs and outputs;

7.3.1.2 will future methods of measuring productivity (as considered by Atkinson et al and the Office of National Statistics) produce radically different methodologies for measuring public sector productivity; and

7.3.1.3 what has happened to NHS wide productivity since 2000 to the present time?

7 3.1.4 This left the following questions to be addressed by the data collection element of the research:

7.3.1.4.1 what has happened to productivity in the four case studies between 2005 and 2008;

7.3.1.4.2 has the introduction of PbR led to greater management and board focus upon understanding costs of individual procedures within FTs;

7.3.1.4.3 has the introduction of PbR resulted in FTs developing and implementing action plans to align health care costs to the relevant HRG under PbR;

7.3.1.4.4 do concerns about an FT's long term financial viability produce greater organisational focus on PbR and productivity

7.3.1.4.5 has the introduction of PbR acted as a catalyst for clinicians understanding of, and taking responsibility for, not only the outputs of clinical care but also the costs of inputs; and

7.3.1.4.6 has PbR produced a greater alignment between the fundamental interests of clinicians and managers? If so, how and why?

7.3.2 Analysis

This section will address each of these subsidiary research questions in turn and then bring together the analysis in a final review of the central research question and a conclusion.

From the productivity data (both RCI and productivity metrics) the answer to the first subsidiary research question, as to what had happened to productivity in the four case studies between 2005-8, is that each of the case studies had seen variations in productivity on various measures over the period, but there had not been sustained progress on productivity in any of the FTs.

The conclusion that there had not been any sustained improvement in productivity, in the case studies is in line with Appleby, Crawford and Emmerson (2009)'s findings that at best productivity in the NHS has been flat over recent years.

With regard to the second question - has the introduction of PbR led to greater management focus upon understanding costs of individual procedures within FTs - the results of the documentary search indicate that at board level PbR/tariff has been mentioned in the case study minutes on a regular basis but does not appear to have caused a link to a discussion of productivity, merely to a discussion of income. As an explicit driver PbR does not appear to have driven the focus of boards on to the costs of individual procedures. However as one of the Finance Directors noted "PbR has set the context in which all decisions are made". There is no evidence that the context has caused a focus on productivity.

In addition, from the search of the documents, there is no evidence that boards have increasingly focussed upon the costs of delivering individual services. In fact over the two year review of board documents two of the boards paid very limited attention to the discussion of costs with regard to individual services although one, FT BB, paid more attention to these issues during a short period of financial pressure.

This finding raises the issue as to whether it is actually external pressure which forces management teams to focus upon the key elements of running a business and therefore is it is important to use regulatory, or financial, pressure on NHS management teams to ensure that they focus upon productivity. This is, in part, the position of those who have promoted the target culture of the NHS in order to promote progress on access, and latterly, quality. Productivity targets have, to date, not been applied.

It should be noted that several of the respondents commented that at an operational level there was an increasing movement to understanding costs of individual procedures. The mechanism for promoting this interest in the costs of individual services appears to be the introduction of SLR. The momentum for trialling this approach to understanding the costs of individual procedures has been heavily promoted by the regulator, Monitor. A group of FTs benefitted from seed funding to implement SLR.

FT AA had been one of the FTs to trial SLR in one of their specialities and the results from the board minutes indicate that, of all the case studies, FT AA was seeing SLR as a method of promoting the efficiency agenda within the organisation via understanding the costs of individual procedures.

Interviews with those connected with the SLR project of FT AA, and board members supporting the project, saw opportunities not only for understanding and driving the efficiency agenda but also by linking quality indicators into SLR promoting quality of care within the hospital. Although FT AA evidenced board and operational level support for SLR as a driver of productivity improvement there was a general acceptance by those interviewed, across all the FTs, that SLR was a key element in the promotion of productivity improvement in the organisation as it provided the data and understanding necessary for productivity issues to be addressed.

The above discussion surrounding SLR links neatly into answering the third question: has the introduction of PbR resulted in FTs developing and implementing action plans to align health care costs to the relevant HRG under PbR?

At the time of the research none of the case studies were in a position to say that SLR had been fully rolled out to all parts of their hospitals. In the most advanced cases it appeared that SLR was only being trialled in discrete specialties as management teams were cautious about some of the unexpected consequences that might arise from the information that SLR produced. For instance, one concern noted was that if a specialty was producing a surplus then clinicians would probably argue for that surplus to be re-invested in the services of that specialty. This clearly conflicts with the concept that surpluses are retained centrally and allocated by central management.

As the research results have indicated that PbR has acted as a backdrop to decision making by the case studies, it might be expected that hospital management would have implemented a strategy to align hospital costs with the relevant HRG under PbR. Evidence from the interviews suggests that, when organisations believe that the tariff could undermine the financial stability of the hospital, then action is taken by the management teams to reduce the costs of the organisation. However there was very limited evidence to suggest that management teams had sufficient cost information to accurately align the costs of an individual treatment to the relevant HRG across multiple procedures.

The reasons for this inability to align procedure costs to the relevant HRG were probably threefold. Firstly, as previously mentioned, hospitals do not fully understand the costs of delivering the individual services they provide. SLR, if implemented and supported by data collection systems which are accurate will probably be the first time NHS hospitals will have

had a management model which permits them to understand the costs of delivering individual treatments. At the time of the research SLR was only in its initial stages of rollout. Secondly, as will be discussed later, clinical engagement with understanding the costs and related revenue associated with various treatments was generally low; any review of care pathways to align procedure costs to HRG requires clinical engagement. Finally, at the time the interviews were conducted, none of the FTs were facing current financial pressure and the central debate in the NHS had moved to a quality agenda. Under such conditions it was probably more difficult to have a discussion about efficiency; the pressure for productivity improvement had been weakened by the DoH stimulated discourse on quality.

The issue concerning pressure brings us to the fourth subsidiary research question: do concerns about an FT's long term financial viability produce greater organisational focus on PbR and productivity?

The research results, and the intuitive conclusion to this question, are aligned. Firstly, the productivity improvement for FT BB during its period of financial pressure clearly showed that its relative costs compared to other providers in England decreased significantly. Secondly, the document review showed focus upon efficiency, length of stay and tariff by the board during the hospitals period of financial stress. Finally, interviews with the management and clinicians confirmed the financial focus of the organisation when under that financial and therefore regulatory pressure.

The final two subsidiary research questions to be addressed fall into two areas. The first question focuses upon clinical engagement with financial control and the process of care and the final question addresses the alignment of managerial and clinical agendas.

First, the question as to whether the introduction of PbR acted as a catalyst for clinicians understanding of, and taking responsibility for, not only the outputs of clinical care but also the costs of inputs?

In order for there to be a real probability of PbR acting as a catalyst for clinicians understanding and taking responsibility for the costs of care, PbR would probably have had to have had an operational influence throughout the organisation. As indicated by the review of the board minutes, PbR has not been a particular focus of the boards of hospitals and results from the interviews indicate that generally clinicians, at operational level, are not

aware of the costs of the procedures they deliver, nor the payment the hospital receives for the service they provide.

In instances where SLR was in the process of being introduced in a speciality, then the interview data suggests that some clinicians become increasingly engaged with understanding the costs of delivering (and payments the hospital receives) from the service. A critical hurdle in SLR promoting that engagement is that clinicians must have belief and confidence in the accuracy of the data on which SLR relies. The accuracy of that data rests on the completeness of the activity coding system within the hospital which, as the Audit Commission (2008) notes, is often of questionable accuracy.

PbR is therefore only setting the background for promoting clinical engagement with the costs of delivering services; it appears that it is SLR that provides the potential vehicle for engaging clinicians. SLR, if used well, may be a key vehicle for promoting clinical engagement and as a consequence productivity improvement.

The final question the research aimed to answer was, has PbR produced a greater alignment between the fundamental interests of clinicians and managers? If so, how and why?

The key variation that the interviews identified in respect of the differences in the fundamental interests of clinicians and managers was that although both groups were perceived as driven by public service, career progression and domestic financial stability the professional interests of clinicians tended to be connected with the furtherance of their speciality, their specialist skills and peer recognition within their specialty. Professional success for a manager depended upon the achievement of the corporate objective of the hospital; or achievement of the manager's contribution to that objective.

As the research results have indicated that PbR has had such a low profile within the hospitals operationally, it is no surprise to find that there was no evidence that PbR had resulted in a greater alignment of clinical and managerial objectives. For alignment to occur there probably needs to be some bridge created where the interests of the hospital at large are considered to be synonymous with the furtherance of the interests of individual specialties and the clinicians that work within them.

It is possible that a combination of a tougher financial climate, forcing the NHS to tackle cultural issues, continued robust regulation by Monitor (ensuring continued delivery of

financial objectives by FTs) combined with the proliferation of SLR might create an environment where the pursuit of productivity improvement is recognised as both desirable and achievable by clinicians and managers alike.

7.4 CONCLUSION

This chapter has applied the research results to the subsidiary research questions and this section takes those answers and concludes on the central research question of the thesis namely:

Whether the introduction of PbR in FTs (in the acute sector of the NHS) led to a greater management focus on, and improvements in, productivity and if so, why?

The research has provided little evidence that the case study FTs have delivered a steady record of productivity improvement; although there has been some productivity improvement achieved in specific areas by all the FTs over relatively short periods. These improvements have often been reversed in the medium term.

The results also indicate that PbR has had a relatively low profile as a concept, and as an express driver of productivity, both at board and operational level within the FTs. This is probably because, at the time of the research, FTs did not have the data and management systems in place to allow PbR to drive the productivity agenda. This largely remains the case in 2012.

The research did produce some interesting results with regard to three other drivers: regulatory influence; focus upon productivity when organisations are under financial pressure and the potential for SLR to promote clinical engagement in the costs of delivering healthcare.

The dominance of Monitor (the primary FT regulator) on board focus is an unexpected but very interesting result. Monitor is considered a clear and robust regulator and possibly because of its strong powers of intervention has significant influence on the focus of FTs and their boards of directors. This influence, combined with the evidence from this research that the case study FTs have not particularly focussed upon or delivered productivity improvement of their own volition, raises two key questions. Firstly, is NHS management culturally orientated to central command and control and in order perform requires the

previous central direction provided by the DoH to be replaced in some form? Secondly, if this is the case, is there an opportunity for Monitor to take over this 'direction' function by changes in its regulatory framework? These issues are discussed further in Chapter Eight.

The result that the greatest short term productivity improvement and focus by the board of directors upon PbR (tariff)/cost improvement occurred at the FT facing the most challenging financial environment indicates that pressure for change, be it financial and/or regulatory, might be a pre-condition for productivity focus and improvement by FTs. If this is the case then the anticipated poor financial conditions for the NHS in 2011-14 may provide a catalyst for productivity improvement.

The perceived significance of SLR, as a medium for engaging clinicians with productivity improvement, is also of interest. Monitor has been consistent in its support for SLR but its operational rollout, within the case studies, was limited. Should the effective use of SLR be a pre-condition for successful clinical engagement with cost control and productivity then this could be a key area on which FT boards should focus.

Finally, the research results indicated some FT boards neither focussed heavily on quality or productivity during the period of this research. There is therefore the interesting question of how these boards are adding value to their hospitals?

The final chapter explores the policy implications of these findings both from the point of view of operating the NHS in its current structure and in terms of the Liberal-Conservative Coalition Government's future plans for the NHS.

CHAPTER EIGHT

POLICY IMPLICATIONS AND OPTIONS

"We can't solve problems by using the same kind of thinking we used when we created them "

Albert Einstein

8.1 INTRODUCTION

The previous four chapters have presented and analysed the research results. This chapter builds upon the analysis and considers potential policy implications with regard to the NHS productivity agenda, the role of Monitor and the future of decentralised NHS hospitals operating within a quasi market. This chapter then moves on to identify some of the key limitations of this research, given the resource constraints any PhD research must face, including limitations of the data collection and the generalisability of the results. The chapter concludes by considering what other research could be conducted which could build upon this work or issues the research has identified which, although not directly aligned to PbR, might be of interest to others.

8.2 POLICY IMPLICATIONS CURRENT OPERATIONS

8.2.1 Research Key Conclusions

The research results and analysis in Chapter Seven lead to three broad conclusions:

- PbR has not resulted in an alignment of clinical and managerial incentives and has therefore not promoted productivity and wider performance of the case studies;
- Limited evidence existed of board engagement with productivity; and
- The case studies appear to respond to central direction and control.

The policy implications fall into two distinct categories. Firstly, what are the implications for policy in terms of operating hospitals in the NHS under current conditions and in particular delivering the productivity improvement currently being demanded by NHS leaders? Secondly, what policy implications might there be for wider healthcare strategy in England, particularly in respect of the Liberal –Conservative Coalition Government's Health and Social Care Act 2012. The discussion starts with operating hospitals under current conditions.

8.2.2 Productivity

In the current financial climate, particularly in circumstances of 'tepid' funding requiring NHS productivity improvements of between 3.4 to 7.4 per cent per year between 2011-17 (Kings Fund 2009), the DoH is using the level and calculation of tariff under PbR as an explicit lever for driving productivity improvement.

It is highly likely that the use of the PbR/tariff lever will result in a continued reduction in tariff paid for services; for instance the 2010-11 NHS Operating Framework introduced 30 per cent marginal cost pricing for emergency admissions above those levels recorded in 2008-9. In addition, the 2011-12 NHS Operating Framework has implemented a reduction in tariff of minus 1.5% for 2011-12 and indications are that that level of reduction may continue for several years.

The analysis of the research results in Chapter Seven indicates that this policy may not work. The majority of FTs in this study did not appear particularly engaged with productivity improvement or cost control or in the relationship between these factors and tariff under PbR. This is reflected in the fact that a majority of the case studies failed to produce a sustainable and consistent improvement in productivity during the period of the research. This seems to have been because the boards of directors of the case studies did not appear to focus on productivity related issues and the use of SLR data, to allow clinicians and managers of hospitals to drive productivity improvement, was not widely available at operational level. The 2012 Kings Fund SLR report (based on seven different case studies) suggests that SLR use within the NHS continues to be highly variable (Foot et al 2012).

If the above remains the case it is unlikely that within the timeframes necessary (funding to be severely constrained financial year 2011-12 onwards) NHS organisations will be able to produce a sophisticated and targeted review of the clinical care pathways they provide to target productivity improvement at areas where there is real opportunity for efficiency improvement.

This kind of structured, evidence based review of clinical care and processes requires not only the development of skills and capacity within an organisation (which takes time and resource) but, as we shall discuss later, requires engagement of clinicians stimulated by effective credible data. This is not something which can be delivered overnight. A more likely response is to require across the board service cost reductions irrespective of the efficiency of individual services: the traditional approach of the NHS.

In the absence of a greater understanding of productivity within FTs, and the continuation of across the board cost improvement programmes, the implications of the traditional approach to tough financial conditions are likely to be a combination of the erosion of quality, as already efficient departments are pressed further to achieve across the board cost improvement targets, while the potential gains from improving relatively inefficient service delivery (and a reduction in inappropriate clinical care variation) are not realised in other services.

If informed, yet robust, productivity improvement is not achieved by FTs then the likely reaction of FT boards will be to attempt to exit those services which are significantly above tariff. In areas which do not have multiple providers (for example rural areas) this may lead to a deterioration in service coverage. A condition of every FT's Monitor licence is the delivery of the Mandatory Services. A clear policy implication therefore is that Monitor may need to force FTs to continue to provide those Mandatory Services to ensure service coverage.

8.2.3 Central Control

A general theme of Government policy since the early 1990's (with the introduction of "autonomous" NHS trusts, in the early 1990's, and creation of FTs in 2003-4) has been a shift to more decentralised management of acute services with hospitals being accountable to

their local populations for the services they provide and development of a quasi market in healthcare. The policy implications with respect to FT management and the quasi market will be dealt with in the next section.

The research results raise the issue of what boards of directors of FTs focus their attention upon. The results indicate that at the time of the research the four case studies were not heavily focussed upon productivity issues or the quality of the services they provided. For instance, the concept of productivity was only recorded in the minutes about one in every 4 meetings and quality of services, although noted more often than productivity, was recorded less than once in every meeting.

In contrast the research has noted the strong (and unexpected) dominance of Monitor, the FT regulator, in influencing the activity and focus of boards. As discussed in the analysis chapter, Chapter Seven, the most common reference in the board minutes of all the case studies was to 'Monitor'. In addition, the interviews chapter, Chapter Five, and the analysis chapter, Chapter Seven, highlighted the significance respondents attached to the influence of Monitor on the case studies. What does this indicate about the behaviours of the management of FTs and the non-executive directors which serve on those boards?

The NHS, since its creation in 1948, has been subject to central direction and control. The creation of NHS Trusts from 1991 onwards and then Foundation Trusts from 2003 to the present day heralded a movement from central control to local accountability. But the results indicate that, without central direction, prioritisation and focus of appropriate organisational effort FTs do not focus on productivity and quality issues. Is NHS management culturally conditioned to central direction from Whitehall?

The results from the Board minutes review illustrate that the most prominent influence on Board agendas and focus was Monitor and the interview responses support this proposition. Monitor's influence can be interpreted in two ways. First, that Monitor has used a regulatory framework which has been clear and robust encouraging boards to respect the advice and position of Monitor on regulatory matters. Monitor has then used that authority well, encouraging the roll-out of SLR and that this, with greater board competency as a consequence of the FT authorisation process, will lead to improvement in productivity as boards have the tools and information effectively to manage their businesses.

The less positive interpretation is that, as FTs have been removed from the operational control of the DoH (FTs beng directly accountable to Parliament and their members), rather than releasing these organisations to become innovative and driving forces for the improvement in quality of service and productivity they have instead looked to Monitor (as the main regulator of FTs) to replace the traditional function of the DoH. Under this interpretation, FTs now look to Monitor for direction as NHS organisations are more comfortable with central direction and control as opposed to localised decision making.

In this context it is interesting to reflect upon the dynamics which were at play between Monitor and the DoH immediately prior to the May 2010 General Election. It appeared that Monitor was trying to justify its position of being an independent regulator by arguing that its method of regulation had led to financial savings and improved quality by the FTs it regulates. A recent report commissioned by Monitor, Measuring Monitor's Impact (Monitor and Frontier 2009), argued that the process of FT application has directly led to savings of £271-389 million and also that the Monitor approval process also leads to reductions in MRSA rates and faster access to elective services by FT applicants. What is interesting is that the report notes that there is no evidence to suggest that, once through the selection process, FTs go on to outperform non-FTs in either financial or non-financial performance.

To some extent this would fit with the notion that NHS organisations, whether we call them FTs, Primary Care Trusts or NHS Trusts, are run by executive management teams that have been developed in a culture of central direction and control and that they perform best when being pressed directly from the centre. The Monitor authorisation process is an intense detailed review of the organisation which sets clear hurdles for organisations to jump through in order to achieve FT status. This setting of hurdles and objectives is similar to the kind of control traditionally exercised by the DoH.

The reduced access times of maximum of 18 weeks from referral to treatment, reduced Accident and Emergency waiting times to maximum four hours and improved cancer survival rates over the period of the Plan certainly indicate that targets can drive progress and many of those targets were set because of the control the DoH exercised over the NHS.

If NHS management, and the organisations they lead, do respond more effectively to central direction and control then it may be that, as the NHS enters one of the most financially challenged periods of its history, a management model of central command and control and

targets might be a more effective approach of achieving financial stability than relying upon autonomous boards to deliver innovation and performance.

It is probably worth noting that the lack of focus of boards on productivity could be partly due to the cash rich environment the NHS has been working in since the introduction of the Plan. With real growth in resources being as high as 7.5 per cent per annum (NHS Plan 2000) boards have not really faced the opportunity cost of investment decisions and therefore the difficult task of driving productivity improvement has not been necessary. If NHS management does react better under conditions of pressure and direction then, as long as regulatory performance standards are maintained, the need to deliver services within a no-real-growth environment may result in the creation of incentives, and resultant productivity improvements that did not appear to exist at the time of the research.

Financial pressure in itself may not of course produce the desired productivity improvement. The 'burning platform' effect of financial pressure could be easily quenched by allowing performance in the NHS to deteriorate. For instance, if Monitor (as the FT regulator) was to be less aggressive in enforcing the eighteen week maximum waiting time from referral to treatment (RTT Target) then, everything else being equal, the required amount of activity within the system would fall reducing the need to make more radical productivity improvements. Could this effect actually be occurring? In December 2010 7.8 % of admitted patients waited longer than the RTT Target, by December 2011 this had risen to 8.4%: a deterioration of some eight percentage points in twelve months (DoH 2012). But evidence suggest, that as of May 2012, Monitor is not changing its robust regulatory approach with 18 FTs being deemed by Monitor to be in significant breach of the terms of their authorisation and their boards being required to take corrective action to remedy their poor performance (Monitor May 2012).

8.2.4 Monitor

As the research indicated that Monitor was having significant influence in its regulatory role there is of course an opportunity for Monitor to extend its current light touch approach to regulation (subject to an FT's compliance with its terms of authorisation) and be more directional in its regulatory regime with regard to quality and productivity issues. This could act as a key driver in promoting the productivity agenda.

There is some evidence that Monitor is increasingly willing to consider the delivery of quality targets a key focus of its regulatory role. The failures identified in the quality of services at Mid Staffordshire FT by the Healthcare Commission (Francis 2009) led to a review by Monitor of its regulatory mechanisms. In particular, Monitor's May 2009 Board Minutes (Monitor 2009b) identify the systems it uses to assess clinical governance quality are to be reviewed. With the proposed extension of Monitor's powers as an economic regulator for all NHS funded providers (DoH 2010) it will be interesting to see if Monitor releases the area of quality to the Care Quality Commission.

If the research is correct, and Monitor is in a strong position positively to influence FTs due to its regulatory reputation and clarity, then Monitor might be able to use arms' length productivity indicators to promote improvement. For instance, Monitor's regulatory framework reviews FT plans but does not specify minimum performance criteria. It might be that a regulatory expectation of FT business plans to deliver minimum earning levels on turnover (i.e. a minimum EBITDA) or minimum returns on assets employed) would encourage FTs to make their hospitals more efficient. This in turn could lead to a review of clinical pathways and processes and therefore drive productivity.

Although the above technique would be similar to the current approach of setting national performance targets (e.g RTT Targets), as the performance criteria would be strategic high level objectives, it would allow FTs to decide how the objective(s) were to be achieved rather than the more operational micro-management targets that the DoH has traditionally employed. The latter approach has, according to some academics, led to negative consequences with regard to the quality of clinical care (Bevan et al 2006) and with NHS management paralysis (Blackler 2006).

Monitor could also extend its willingness to set standards for FTs by exerting influence over the board membership of their boards of directors For instance, it could influence the appointment process of directors to ensure they had sufficient understanding of the business of hospitals (especially with regard to non-executive appointments) and requiring operational directors to demonstrate commercial capacity. This approach is analogous to the powers of the Financial Services Authority when approving the appointment of directors to the boards of Banks; a point highlighted by Turner in his report on failures in the banking sector (Turner 2010).

The policy implication of the above may suggest that, due to the NHS's cultural history and its comfort with central control, then autonomous decision making at local levels within the NHS is not appropriate. The extension of Monitor's role as a driver of productivity and quality improvement may be a realistic policy option, given its reputation and clarity as a regulator.

8.2.5 Clinical Engagement

The research results also indicated that the alignment of clinical and managerial incentives had not occurred with the introduction of PbR . What might this indicate about the productivity agenda over coming years? In particular, to what extent clinicians are likely to be engaged with the need for identifying productivity improvement during the period 2011-14?

There is currently much discussion within the NHS about clinical leadership, change management and productivity techniques such as Lean. David Nicholson, the Chief Executive of the NHS, is on record as saying (Pathiraja and Drysdale 2010) that his aspiration is that every NHS chief executive post advertised should receive an application from a clinician, as opposed to candidates being drawn purely from the traditional general managers created by the Griffiths review of 1988. For this transformation of NHS leadership, clinical engagement with the management agenda will be critical and the alignment of incentives between management and clinicians probably a pre-condition for change.

If, as the research suggests, there has not been a significant alignment of those incentives (be it from the introduction of PbR or other drivers) then there is significant doubt that the adoption of the leadership agenda by clinicians is likely to occur in any material way. The Nicholson vision therefore appears to be a hollow policy aspiration.

The productivity agenda is also heavily reliant upon the active leadership of clinicians in re-modelling the delivery of clinical services both within organisations and across organisational boundaries. Experience of change management in USA healthcare, as exemplified by the introduction of Lean techniques in US hospitals such as Virginia Mason, Seattle and the improvements in medical service quality delivered by the Department of

Veterans Affairs, both identified significant clinical leadership and alignment of incentives as critical for success.

In the case of Virginia Mason the pre-condition for the success in introducing and acquiring the efficiency and quality benefits from Lean was a 'Compact' between management and clinical teams. The Compact was effectively the alignment of the clinical and managerial objectives where both groups developed a patient first, defect free, no waste culture to drive efficiency improvement.

Much of the process, procurement and behaviour changes required to deal with the productivity agenda in healthcare can not be addressed without clinicians acting as promoters and drivers of change. In particular, clinical practice and changes in clinical care need to be owned, and to a large extent driven, by clinicians with general NHS managers providing the technical and practical support to implement the changes in care pathways. If this level of clinical engagement does not exist with the productivity agenda then those changes will not occur and the large productivity gains (both quality and efficiency) from clinical care pathway review and development will not be delivered.

In a "cold' to 'tepid' funding environment this lack of clinical/managerial alignment could significantly contribute to the risk of financial failure within the NHS. It is therefore critical that leaders, both managers and clinicians, acknowledge the lack of alignment and identify levers (such as engagement with meaningful data via SLR) which will promote clinical engagement with the productivity agenda.

In order to develop meaningful clinical engagement it may be time to move away from notions of controlling professionals and follow Nantha's view set out in Chapter Three that we need to develop the intrinsic motivation of doctors and move away from the controlling approach adopted by the NHS and other health systems (Nantha 2013). If this was combined with the findings of Humphrey and Russell (2004) (please see 3.5.1) where NHS general management create opportunities and conditions for clinicians to proactively influence the strategy of the service they deliver and provide opportunities for them to innovate and be respected and valued then clinicians may not work wish to work in the private sector (as identified by Humphrey and Russell) but make a greater contribution to public services.

8.2.6 Service Line Reporting

An interesting observation from the interviews conducted was that the introduction of SLR appears to be viewed by many managers and clinicians as a key information tool required for productivity issues to be effectively addressed in an organisation. At the time of the research there was little evidence that SLR was being used at board level; although FT AA appeared to be considering issues around implementing SLR reporting. From a policy perspective this support for the potential benefits of SLR should reinforce Monitor's willingness to champion the introduction of SLR and perhaps even formalise a commitment from FTs to commit to SLR within its authorisation or compliance frameworks.

Should the effective introduction of SLR be a critical tool for clinical engagement with the productivity agenda then one of the key barriers to effective implementation of SLR must be addressed: that of data quality. The data used in SLR is based upon the activity coding within the hospital. The Audit Commission's data quality report for 2008 noted that this was of questionable quality although more recent reports have suggested steady but slow improvement. The promotion of data quality may therefore be a key priority for FT boards and regulators to allow the benefits of SLR to be realised.

Catherine Foot and colleagues have identified that SLR has led to tangible service changes in some organisations, but for SLR to be effective boards of directors have to be willing to devolve responsibility. Foot et al note that for SLR to work boards have to stop performance managing and become capability builders and clinicians need to be involved in developing the reporting system rather than it being done for them (Foot et al 2012 p8).

8.3 STRATEGIC POLICY IMPLICATIONS

So far the discussion has focussed upon policy implications in terms of the day-to-day operations of the NHS as it is currently structured. The discussion now explores possible implications for the quasi market for healthcare in England and then looks in detail at seven policy options available.

8.3.1 English Quasi Market in Health

As discussed in 2.3 above, since 1990 English health policy has shown a general movement to decentralised NHS providers competing with a small, but increasingly significant, group of private sector providers delivering publicly funded health care. The market element has been encouraged by the supported entry to the market of private acute providers who are offered enhanced tariff payments to support the costs of capital development and to overcome the barriers to market entry.

An assumption of this policy has been that acute FTs, directed by competent boards of directors, will compete with private providers within the quasi market to encourage improvement in quality and a reduction in the costs of services provided. The Liberal - Conservative government has committed itself in its White Paper on NHS reform (DoH 2010) and the subsequent Health and Social Care Act 2012 to further promote this model of quasi competition by allowing local general practitioners, acting as agents for their patients, to directly commission services from acute providers via the creation of clinical commissioning groups. A similar policy that was introduced in 1991 in the form of GP Fundholding, was reviewed by Le Grand et al (1998).

For the quasi-market to be a positive force for the development of more efficient NHS services the boards of directors of FTs need to have the capability to rise to the challenge of the quasi-market. If the boards of FTs are not capable of dealing with productivity and quality challenges then it is possible that the private sector will take advantage of this relative weakness in leadership capability, identify low complexity homogenous treatments which the private sector can produce efficient profitable pathways for, and potentially eliminate FT competition in these areas. Private providers such as Circle Holdings Plc appear to believe that their partnership model with clinicians is effective at aligning corporate and clinical incentives to produce such a comparative advantage in the market. As Ali Parsa (Chief Executive of Circle) recently noted Circle has:

"a passion for reengineering healthcare delivery to make it simpler, better and smarter value for the patients. Circle arrives not with a top-down plan to impose change, but with a proven

methodology of unleashing NHS professionals' talent through clinical leadership and devolved decision-making (Parsa 2011)."

If the private sector was successful at targeting homogenous treatments and standardising pathways as discussed above this could leave FTs, and the state acute sector in general, with complex, co-morbidity patients which require much greater resource usage. This could leave many NHS organisations with the problem of trying to deliver complex patient care, at an unreasonably low tariff price, thus presenting a significant threat to quality.

So does the research indicate that the implicit policy belief, that innovative FT boards are able to deal with the challenges of productivity and quality and can compete with private sector providers, is flawed? Certainly, as discussed earlier, the research indicates that quality and productivity agendas have not been the main focus of the four FT case study boards and that productivity improvement has not been sustained in any of the four FTs.

The research results raise the question of the capability of those FT boards to deal with the big issues. In a successful quasi- market model the non-performance of those FTs would lead to changes in management as stakeholders of FTs (i.e the governors representing commissioners, public and staff whose role it is to hold the board of directors to account for the performance of the organisation) demanded changes in the performance of the acute providers and improvements in quality and productivity.

However, recent evidence from the Mid Staffordshire review (an acute FT which failed to provide effective safety and leadership of clinical services) indicates the stakeholders of the FT were not aware of the deterioration in service quality or financial standing, and were therefore incapable of demanding improvements or replace the board of directors (Francis 2009).

The regulator of FTs, Monitor, has recently emphasised the need for FTs to show greater accountability to the membership to overcome these constraints but it is questionable the extent to which unpaid and diverse memberships, often under-resourced and trained by the boards they should hold to account, can effectively execute that role. The Francis Report into Mid Staffordshire noted that quality issues were known about within the community

served by the hospital and the Governors of the trust had failed to take action to hold the board to account for the quality failings.

If the research is correct, and the FT boards are not focussing upon quality and productivity issues, and Monitor's concerns about the ability of governors to hold those boards to account for performance is justified, then Monitor will be increasingly required to act as guardian of FT performance and use its intervention powers. Since Monitor's creation in 2004 it has had to use its formal intervention powers on twelve occasions. Ten of those interventions have occurred in the 15 months leading to July 2010 suggesting a capability gap is emerging. Monitor may well be increasingly required to take regulatory action within the sector.

However, for those who argue for the pro-choice quasi-market, the potential policy conclusion that the NHS performs best when subject to central direction would be a regressive step - even if it is Monitor that exercises that control. An alternative policy prescription might therefore be that FT boards capacity and capability needs to be further developed so that innovation, productivity and quality can be driven by local organisations competing within the quasi market for health.

The May 2011 Kings Fund Commission review of NHS Leadership emphasised the need for individual organisations to take responsibility for leadership and management development. The Commission particularly noted the importance of the development of governor capability within FTs (Kings Fund, 2011). This will be of particular importance should Monitor adopt a more distant role as economic regulator with less powers of direct intervention.

A lever that might encourage this improvement could be the ability of the stakeholders of poorly performing FTs to have the right to sell the business and assets of the hospital to a competing private provider. Clearly, this approach would require the introduction of significant safeguards as hospital governors would effectively be selling public assets as well as potentially impacting on the distribution of health services in the area.

An alternative option might be greater support for the entry of private sector management teams into the NHS by the use of franchising agreements such as that implemented by the Hinchingbrooke Health Care Trust. Hinchingbrooke has recently appointed Circle (a private sector provider of clinical services) to operate the management franchise of the Trust for ten

years from the 1st June 2011(Hinchingbrooke 2010). These and other policy options are discussed in more detail below.

8.3.2 Seven Policy Options

If the research is correct that NHS de-centralisation, as currently structured, may not produce the high quality, productive and responsive services required then what are the possible ways forward? The discussion now explores seven main options which are:

A. The roll back of the FT movement with a halt being called to future authorisations and either a wholesale reversion of the FT movement to the traditional form of NHS trusts or even an abolition of the purchaser/provider split;

B Reversion to the pre-1990 structure of direct command and control of all hospitals and organisations from regional offices of the NHS. Alternatively, a freeze on the creation of FTs but with hospitals being permitted to continue with their FT status as long as they fully comply with their Monitor terms of authorisation. Significant breach of that authorisation automatically causing a reversion to non-FT status;

C The third option would be to argue that the de-centralisation of the NHS in the last decade has not been sufficiently radical as all the NHS has done by the creation of FT's is to change the title on the management offices of those organisations without creating cultural change within them. This analysis argues that the managers running these organisations prior to FT status are broadly the same people who were managing the organisations under conditions of central management and control; the key difference being that they now receive higher salaries to reflect supposed increased autonomy. In this case the policy option would involve the compulsory tendering of FT management to private sector management teams.

D Option four would be to adopt the view that FT management teams can deliver on the productivity agenda as long as the correct conditions are met to promote performance of the hospitals. This option might consider what outside conditions would be required to promote improved management performance, for instance the form and effectiveness of stakeholder pressure being applied to the FT, particularly the effectiveness of governors of FTs in holding the boards of directors of those organisations to account for performance.

E Option five is the position the private market lobby might argue, that the above options are merely tinkering with a broken system and that the productivity and efficiency agenda in the NHS (as with other public services) will not be delivered because the critical market disciplines are not present in a public or even a quasi-market context. For instance, the inability of a private company to provide stakeholder value and good products to customers will lead to the insolvency and market exit of such providers. For this group the selling-off of FT assets to private providers would promote real competition between deliverers of care with the NHS acting as funder of care (perhaps through the medium of larger integrated care commissioners similar to Kaiser in the USA).

F Option six, which would probably work alongside all of the previous possibilities, but could not fully replace current structures, could be the development of social enterprises or mutuals where stakeholders such as clinicians, activists and members establish social enterprises for the delivery of services . This kind of structure would allow operating surpluses to be re-invested in the quality of services to patients. The assumption of this model is that the best people to run and deliver a service are those who actually use and operate it on a daily basis.

G Finally, a policy option might be one of wait and see. The central premise of the thesis is that involvement of clinicians in the productivity agenda is the key requirement for productivity to be delivered. It may merely be an issue of the passage of time, allowing the effective roll-out of service line management so that clinicians are touched by PbR and the commercial reality as to the financial sustainability (or not) of their services is allowed to have an impact on behaviours. Supporters of this option might point to the “burning platform” of NHS financial crisis as being the agent for progress as services and clinicians are forced to address the efficiency of the clinical pathways of care.

These policy options will be explored in a little more detail with a focus being placed upon what advantages each option may deliver in the context of driving productivity improvement while also setting out some key limitations of each option. Let us first consider the option of de-registration.

8.3.2.1 De-registration

As previously discussed, the creation of independent NHS trusts in the 1990s, and then the further development of the concept of organisational autonomy for hospitals by FT status, was predicated on the concept that if the "shackles of central management and control" could be removed from publicly owned organisations then the drive of managers and clinicians would lead to advances in quality, innovation, efficiency and productivity improvement producing a more dynamic, responsive service to patients. If the research is correct and NHS management respond better to direction and control (as opposed to being generators of innovation and quality) then the de-authorisation of FTs and reversion to central control could be a realistic policy option.

At present, Section 15 of the Health Act 2009 (the Act) allows de-authorisation of FTs in circumstances where Monitor considers the FT is "seriously" failing to comply with its terms of authorisation (or requirement imposed by any enactment) and the seriousness of that contravention or failure is sufficient to justify the Secretary of State making an order to de-authorise (Section 52B of the Act). The Secretary of State can also request Monitor to consider de-authorisation and Monitor must then respond within fourteen days as to whether it will formally request the Secretary of State to use his Section 52D powers to de-authorise the FT. On de-authorisation the FT would revert to the status of an NHS trust and would be subject to the directions of the Secretary of State and thus the command and control functions exerted by the Department of Health and their agents the Strategic Health Authorities.

Monitor's March 2010 consultation paper on the way it plans to exercise its powers of recommending de-authorisation is clear in that it will be an "act of last resort" and will only do so when it has "fully exhausted its regulatory powers" and the use of those powers will still be likely to leave the FT in an unsustainable position (Monitor 2010). Given the wide powers and influence that Monitor has over the leadership of organisations within the FT sector, it is probably unlikely that it will exhaust its extensive regulatory powers and so de-authorisation through this method is only likely to happen in exceptional circumstances if at all.

The Secretary of State's powers to request Monitor to consider de-authorisation still leaves the decision making process within the control of the regulator and, in the light of the above discussion, Monitor is unlikely easily to concede such a request. However, the recent change

in leadership of the regulator (both Chief Executive and Chairman) may lead to a change in regulatory position with respect to political influence over the medium term.

In terms of future authorisations of FTs, the economic environment, coupled with a majority of the financially stronger organisations already having been authorised, might have created a natural restriction on the number of future authorisation of FTs. For instance, in 2007-8 30 FTs were authorised, and in 2008-9, 26. In 2009-10 this dropped to 14 and in 2010-11 this reduced to 8 (Monitor 2011b). The much more difficult funding environment of 2011-12 onwards is very likely to lead to the tap of FT authorisations dwindling to a trickle unless Monitor drops the bar for the financial sustainability tests for authorisations – an act unlikely to be supported by proponents of the FT movement.

The third de-authorisation option is that a political decision is taken to pass primary legislation to de-authorise all FTs. If the political will existed to remove the independence of FTs reverting them to NHS trust status, removing their ability to borrow and making them subject to the directions of the Secretary of State then this would be a relatively simple legal process.

This is a very unlikely in the short term with the election of the Liberal–Conservative government and Andrew Lansley as Secretary of State for Health. Lansley appears fundamentally opposed to a policy of de-authorisation. In the Conservative pre-election publication Renewal-Plan for a better NHS the party was explicitly supportive of a policy of provider pluralism pressing for an extension of FT status and allowing private providers, social enterprises and FTs to compete for the right to provide services to the NHS. The new government's commitment to the continuation of the FT sector has been further demonstrated in its July 2010 White Paper "Equity and Excellence-Liberating the NHS" in which it emphasises all NHS Trusts will either become FTs or will become part of existing FTs. As at February 2012, as the resultant Health and Social Care Bill passes the House of Lords, the commitment for all NHS providers to become FTs or other independent body remains. Strategic Health Authorities are robustly pressing non-FT NHS provider boards to become either FTs, a social enterprise or merge by 2014.

In circumstances where the Liberal-Conservative coalition fails, Andy Burman, the former Secretary of State for Health, certainly showed himself willing to question and curtail the autonomy of the FT sector by his statements as to a review of the effectiveness of

governance arrangements of FTs (ie the ability of the membership to effectively hold the management of the FTs to account) and his public conflict with Monitor over his desire to make provision for political influence over the decision to de-authorise FTs. Whether any future Labour administration would be willing to roll back the whole policy of decentralisation is less clear.

The policy option of the de-authorisation of FTs is of course predicated on the assumption that the reversion of FTs to central command and control would allow the Secretary of State to use his powers to drive productivity improvement. Given that the NHS has significantly improved access times, as a consequence of central direction and targets, there is an argument that the use of strategic targets (as discussed earlier) to drive productivity improvement could be effective.

8.3.2.2 Franchising

The third option to address the issue of NHS management responding more effectively to command and control is to further develop the franchising of the management of FTs to private or third sector providers. This could be either a mandatory requirement for all FT management teams to be subject to a tendering process at regular intervals, or a more selective approach requiring only non-performing FTs to be subject to a management tendering process.

The willingness of the NHS to consider the franchising of management is indicated by the decision by the East of England Strategic Health Authority to franchise the management of Hinchingbrooke hospital. Also, in 2002, the NHS built in the concept of management franchising in its response to failing NHS trusts who had dropped to a zero star rating in the annual assessments. Good Hope Hospital was one such trust which dropped from a previous rating of three stars to zero stars in the 2002-3 annual assessment.

The Good Hope hospital board signed up a private firm, Tribal Secta, in August 2003 for £1.3 million. Tribal Secta provided one of its employees as Chief Executive of the trust and delivered other support facilities. Tribal's three year franchise contract was prematurely terminated in December 2005, by mutual consent, after being in place for approximately two

years. From December 2005, Good Hope received management support from the Heart of England NHS Foundation Trust which finally led to a merger in April 2007.

A report from the European Services Strategy Unit points out that the aims of the franchise to transform Good Hope within three years with the object of building internal sustainable management capacity and handing management back to the hospital was clearly not achieved. According to the report a financial review by PwC in 2005 indicated a forecast financial deficit of £7.1million in 2005-6. Anecdotal evidence suggests that Tribal was not fully aware of the complexity of the financial situation facing the Trust when it signed-up to the franchise and that freedom to operate the franchise was severely constrained by political factors. On that basis it might be argued that this was not a representative attempt to introduce a private sector management franchise. Irrespective of this, the European Services Strategy Unit report certainly indicates that the franchising of hospital management may not be a preferred solution in all cases.

Other management franchises put in place were at Dartford and Gravesham, Ashford and St Peters, Portsmouth Hospitals and Barnet and Chase. In the case of Good Hope, and these four examples, the common factor was that the franchise Chief Executives had all had established NHS track records; this was a pre-condition for any franchise team being admitted to the approved register. To that extent the issue of NHS management culture change was not being addressed, except perhaps in the case of Good Hope and Tribal Secta, which was bringing non-NHS resource and capability as support into the contract as opposed to franchising agreements which merely provided former NHS managers to run the organisation.

The question is to what extent franchising would amount to a sufficient policy option to create robust drivers within the system to promote productivity growth? Incentives could be built into the fixed term appointment contract which link performance on productivity improvement to payments under the contract and re-appointment at the end of the fixed term. If the indicators were sufficiently sophisticated the productivity agenda could be widened to include the quality ingredients of productivity such as improvement in clinical outcomes and patient satisfaction. The problem is, of course, that although leadership from the top assists the focus of the organisation, delivery of the productivity agenda requires the engagement of operational managers and clinicians with the productivity agenda. It is therefore unlikely that

"top table" management change (as reflected in a franchise agreement) would materially impact on the cultural issues of an organisation in the short term. The short term nature of franchise agreements pose a threat to the cultural change required in any organisation. Anecdotal evidence from the successful introduction of Lean at Virginia Mason in the USA (a successful healthcare provider in Washington State) suggests that stable senior leadership is a key condition for long term progress on productivity.

On the basis of UK experience to date, management franchising has not demonstrated that it could address the cultural issues around productivity improvement in the NHS. It will be interesting to see the success, or otherwise, of the current East of England project at Hinchingbrooke and the ten year appointment of Circle.

8.3.2.3 Strengthening Governance-stakeholder Influence

A fundamental policy objective of the FT movement was that local hospitals should be accountable to the populations they serve. One of the key elements of this accountability structure is that every FT has a group of elected members who serve as governors of the organisation. They include staff and key stakeholder groups (such as commissioners and local authority representatives) and members of the public constituencies (i.e elected members of the general public who use the hospital).

In conditions where this accountability function is effective then this key stakeholder group should appraise the performance of the directors and hold the board of directors to account for the performance of the organisation by means of exercising its powers (i.e. remove and appoint non-executive directors of the FT (including the Chairman of the FT).

Performance of the organisation for these purposes should include the running of the hospital in an 'effective, efficient and economic manner' (Condition 2 of an FT's Terms of Authorisation (Monitor 2004)). This could and should include the hospital delivering efficient services i.e. maximizing productivity within the organisation.

At present there is increasing disquiet about the ability of the governors of FTs to hold the board of directors to account. The recent Francis Report on the failures at Mid Staffordshire NHS Foundation Trust indicated that patient concerns with respect to the quality of services

did not effectively influence the board. Governors were to a large extent unaware of the concerns and did not therefore hold the board of directors to account.

The key elements that appear to be blocking the ability of governors, a key stakeholder group, to hold the boards of FTs to account for performance seem to be as follows. Firstly there is a fundamental balance of power problem faced by a voluntary (non-professional) group of governors being able to hold a professional board of directors to account. The power imbalance probably rests on factors such as technical knowledge of the underlying operations of the business, effective access to the correct form of information and the clear time constraints affecting voluntary groups.

If this group of stakeholders is to be as effective as institutional shareholders of UK public companies in ensuring the boards of directors continue to perform and deliver measures such as increasing productivity then this group must be given greater resources and time to develop their professionalism. Alternatively, the accountability structure needs to be changed so that professional governors are appointed, or the level of support for amateur governors is fundamentally improved.

At present many groups of FT governors struggle with the very basic understanding around the regulatory framework of the Care Quality Commission and Monitor. In a vast majority of cases they are a long way off being able to challenge boards as to the level of productivity stretch within the organisation, the extent to which the annual business plan targets for EBITDA and the return on assets employed are sufficiently stretching to maximize stakeholder value or the extent to which such targets, if stretching, are in line with the delivery of the quality of care to patients.

The above conclusions are supported by Allen and Keen et al (2012), Dixon and Storey et al (2010) and Lewis and Hinton (2008). All this research supports the conclusion that governors are struggling with their role of holding the board of directors to account for the performance of their hospitals. One of the key limits to their effectiveness being lack of clarity as to the governors' role both from the point of view of the board of directors of the FT and the governors themselves. Please see 3.5.1 for further details of the research.

It is unlikely that in the short term the capacity and capability of governors will be able to be developed to act as a major driver of organisational performance and culture change within FTs. Stakeholder power to promote FT performance should be seen as a secondary

improvement to promote productivity as it is unlikely to address the issues in the shorter term.

8.3.2.4 Social Enterprises

A topical policy option, as it forms part of the Liberal-Conservative Government's NHS White Paper, is the concept of a social enterprise. An extension of the co-operative/mutual concept (where organisations are operated for the benefit of their members (usually the customers or employees of the business) social enterprises are managed by the community/employees of the service with any operating surplus being re-invested in the service itself rather than being redistributed to members. This concept has recently acquired some political traction.

The political appeal of this policy option has resulted in all three main English political parties signing-up to the concept of supporting and extending social enterprises as promoted by the Social Enterprise Coalition. An interesting question arises as to the extent to which social enterprises could be potentially used to promote the cultural change and productivity of FTs.

A good example of a health related social enterprise is the Sandwell Community Caring Trust (SCCT). This is a social care service originally delivered by Sandwell Borough Council that required the achievement of significant efficiency savings for the service to be sustainable. Success would depend on the extent to which enpowerment of staff could deliver a cultural change in the organisation delivering improved quality and efficiency.

SCCT was created in 1997 and by 2008 the percentage of turnover spent on front line services had increased from 62% to 82% and the cost of adult residential care had declined from an average of £657 to £328 per week while at the same time improving quality. The quality improvement was driven by maintaining a stable workforce (with staff turnover of less than 4% per year) and absenteeism dropping from 22 days per year in 1997 to 0.3 days in 2008 (Collaborative Communities 2012). Clearly, if the organisation of FTs into social enterprises could achieve a similar 50% reduction in average costs with material improvement in service quality this would be a significant productivity success.

Critics might argue that social enterprises are only effective with relatively small organisations like SCCT and that the large scale nature of an acute FT would not be capable of being operated in this way. The counter to this argument would be the commercial success of the John Lewis Partnership (a commercial retailer owned and run for the benefit of its employees) in recent years. Although John Lewis is not directly comparable with a social enterprise, John Lewis had a turnover of 7.4bn in 2009-10, 70,000 employees and operated from over 250 sites (John Lewis 2010, p1-4). Size does not therefore appear a limitation to the success of mutualism, in the widest sense, so operation of an FT by its staff based upon a turnover of £250-300 million and 4000-5000 staff seems achievable.

It may be that the complexity of an acute FT could preclude it being structured on the basis of a social enterprise. In particular, the complexity of running and organising a hospital with a very heterogenous product line, and a heavy regulatory burden, may provide significant barriers to non-professional established NHS management being able to operate an FT. This might be the case if for instance a group of clinicians wished to operate the FT without previous management experience.

There are of course new models of healthcare delivery that could, in time, provide the management expertise that would allow clinicians to be part owners of organisations like acute FTs. At present market players such as Circle (majority owned by institutional investors but which permits clinicians to have a minority stake in the business by regularly allowing them to subscribe for shares) provides the capital to develop hospitals and the management expertise to run them while allowing clinicians to be ‘partners’ in the business. At present this model has been limited to a relatively small spectrum of services but it could provide an interesting model for the future management of FTs.

In reality there is nothing to preclude professional managers from continuing to operate an FT as a social enterprise, supporting the employees in their desire to transform service delivery without the same degree of centralist direction and control experienced under the traditional NHS trust model. The drawback of this approach would of course be that the hospital would still be being managed by the same group of managers, just a different legal form. This could just be a re-branding and a change in the structure of the organisation rather than promoting any real cultural change.

It is probable that staff engagement with the concept of a social enterprise would be most effective at a speciality or service level where the diversity of the product line is less extensive and the staff/community can more easily identify with a particular service. It is also more probable that the clinicians within the service could actually be able to manage and operate such a social enterprise (due to its relative size compared to a complete hospital) thus creating the change in management culture. Social enterprises could well make a contribution to driving productivity at service level as the proximity of the business and patients to both clinicians and managers respectively could be an effective driver for aligning managerial and clinical incentives. It is probably not the model for operating a complex heterogenous product line seen in an FT.

As noted above, it is important that change in legal structure is not seen as the solution to issues of staff engagement. As Addicott (2011) notes, staff engagement is about effective power in decision-making not having notional ownership either directly (via a share) or indirectly (via some form of trust (for example, John Lewis). Addicott believes it is the staff engagement that allows social enterprises to innovate, not being a social enterprise.

8.3.2.5 Privatisation

The next policy option to consider is the idea of transferring assets of the FT to the private sector. If NHS culture is restricting productivity improvement then a transfer of FTs to private sector hands may well drive up performance of the organisations. The UK certainly has a track record of privatising public assets having sold assets such as British Gas, Britoil and British Rail to the private sector. In the case of British Gas this has resulted in commercial success for the organisation, although British Rail is less of a success story with part of the privatised business, the track infrastructure, being re-nationalised in October 2002 when Network Rail Limited purchased Railtrack Plc from the rail administrator (specific insolvency administration for railways under the Insolvency Act 1986), taking the rail network back into public ownership.

Transfer to the private sector would certainly allow the introduction of private sector management practices into FTs and the organisations could be driven to deliver private sector returns on the assets employed and operating margins. It is highly probable that privatisation

would drive cultural change, although recent strike activity on British Airways (formally a nationalised industry) over changes in working practices suggests that change can sometimes be difficult even when assets are transferred to the private sector.

There would of course be significant political risks to this approach. Firstly, many hospitals are probably unsustainable as businesses (many are relatively small - e.g Yeovil FT turnover of circa £70 million) and will in the current downturn face significant financial risks. In private sector hands it is highly likely that some FTs would become insolvent and cease trading. This could significantly impact on access to services, particularly in rural locations.

Secondly, because of the relative complexity of FT services it is highly unlikely that the private sector would be interested in providing the full menu of services in the first place. Their ability to generate the levels of returns required for private capital investment are unlikely to be achieved in the low volume high cost procedures. This is supported by the experience of private sector treatment centres where, in the first wave of agreements, the DoH had to enter into contracts with private sector providers which guaranteed high levels of activity, and at a price above national tariff (i.e. a higher price than was paid to NHS hospitals), in order to encourage them to enter the English health market. Although some commentators argue that this arrangement merely corrected an NHS cost advantage resulting from NHS access to public funded capital, Dixon, Harrison and Mundle recently noted that "*The revised [Health and Social Care] Bill makes it clear that promotional tariffs cannot be introduced in future to support the entry of a particular type of provider*" (Dixon, Harrison and Mundle 2011, p26}. In addition, private sector providers concentrate on the delivery of non-complex, standardised procedures such as hip replacements. FTs are required to deliver high risk, complex procedures over extensive product lines.

Given the prospect of hospitals facing closure under private sector insolvency rules, and the financial unattractiveness of some product lines of FTs, the privatisation option is possible but unlikely to be adopted on a large scale. The policy may be an option for those NHS Trusts that are not likely to achieve FT status due to structural financial constraints (for instance serving small populations or possessing poor buildings and infrastructure). In these circumstances a combination of transferring services to existing FTs and allowing the private sector purchase of residual assets may be an option the Coalition Government might consider.

8.3.2.6 Wait and See

It is of course possible that the more radical policy options discussed above are not actually required. If the productivity agenda has not been delivered because service line management has not yet brought PbR into contact with clinicians and managers at operational level, then it may just be a matter of time before the large scale introduction of service line management becomes established in FTs and alignment of managerial and clinical incentives occurs and the productivity agenda is delivered. The economic downturn might actually act as a catalyst for a faster introduction of service line management into hospitals. The risk of course is that, under pressure, senior NHS management teams will revert to traditional command-and-control techniques and actually slow down the roll-out of service-line management. In these circumstances, the NHS will have to seriously consider some of the more radical policy options outlined in this chapter.

8.4 RESEARCH LIMITATIONS

This research has produced interesting and unexpected results but remains subject to some key limitations.

The first limitation is the generalisability of the results. The accepted wisdom is that case study research cannot be generalisable. Yin (2003) argues that multiple case studies (as in this research) allow theoretical generalisations but not statistical generalisations. Crosthwaite, MacLeod and Malcolm (1997) illustrate this idea further by explaining case studies as distinct experiments which allow the researcher to theoretically generalise what might happen in other situations under similar conditions. The use of multiple case studies, as in the case of multiple experiments in the science laboratory, provides greater rigour to the analytical generalisations through replication.

The research is clearly not able to extrapolate the results from the four case studies to statistically predict the behaviour of FTs in general, nor the behaviour of clinicians or managers within those FTs. Although this is a limitation, the use of case studies remains an

accepted method of social research and of creating theoretical generalisations, a methodology followed here One must remember that there has never been a double-blind of the effectiveness of parachutes when jumping out of aircraft at 10,000 feet compared to jumping without such parachutes, but theory still persuades us to take the parachute option as opposed to the alternative.

The productivity data, both the RCI and the productivity metrics, although compiled by third party organisations with the benefit of robust quality assurance systems are still subject to data collection errors. The key limitations to the data rests within the quality of the data submissions from the NHS hospitals themselves. For instance, the most recent Audit Commission Data Assurance Framework Report (2009) concludes 12 per cent of activity is still coded incorrectly (down from 16.5 per cent in its 2008 report).

As noted in Chapter Six any conclusions about the extent to which productivity has changed in each of the Case Studies will be subject to the limitation that output measures are ignoring changes in quality. The research briefly highlighted the indicator of emergency re-admissions as an example of a blunt indicator for changes in quality but the introduction of common added value indicators for quality in the NHS are currently not routine. Until quality changes are routinely observed, and recorded by FTs, this is an unavoidable limitation. The introduction of PROMS quality indicators into the NHS and the commitment in the July 2010 NHS White Paper to develop outcome measures are welcome steps forward.

In addition to the quality of data submissions previously discussed the productivity analysis is subject to a further weakness in that when a Trust invests in improved environments for care (for example capital developments to replace outdated buildings) this can result in a much higher depreciation charge which would indicate a higher input cost with no measurable improvement in output.

As significant capital investment has occurred in the NHS over the period of this research then this is a limitation of the conclusions on productivity. It may therefore be that the research underestimates the degree of productivity improvement as the RCI data does not take into account the quality improvements arising from improved environments but does reflect increased depreciation costs within the RCI.

8.5 FUTURE RESEARCH

The research has identified three main areas which need to be further investigated.

Firstly, the results indicate that PbR across the four case studies has not generally aligned the incentives of clinicians and managers in the productivity agenda. The fundamental question that then arises is whether this is because the concept and detail of PbR has not been effectively communicated to clinicians, so that they cannot effectively engage in the productivity debate thus not permitting alignment with managerial incentives, or whether there is a fundamental barrier in terms of incentive alignment which PbR has failed, and will continue to fail, to bridge.

The results from the interviews indicate that clinicians have not been practically touched by PbR rather than PbR not engaging clinicians but further research is required on this aspect.

A key area for investigation may be the degree to which the introduction of SLR, at an operational level, leads to clinical interest in PbR and the productivity agenda. Anecdotal evidence suggests that when clinicians become engaged with the underlying data they are then able to use this to challenge practice, thus driving quality, challenging waste and implicitly promoting productivity.

Secondly, the research indicates that the case study boards do not appear to be spending significant amounts of their time considering productivity or the quality agenda. It seems counter-intuitive, given the primary aim of FTs (as set out in Condition 2 of their terms of authorisation) is to run their hospitals “effectively, efficiently and economically”, that these two areas are not a key focus of board deliberations. Further research is therefore required to identify if FT boards are in fact focussing on quality and productivity but the formal board minutes are not recording this focus or, more likely, that the results are in fact correct. In which case, what do boards of directors focus upon?

Finally, the research has suggested that NHS management may have a cultural tendency to look to centralised direction as opposed to the desire to have local autonomy and make local decisions. The policy implications of this could be significant in terms of management development and/or the centralisation of the NHS. Further research to ascertain whether NHS management performs better under conditions of centralised direction would help inform the

debate as to whether the NHS should revert to a more centralised command and control model of system management.

REFERENCES

Addicott, Rachael (2011). Social enterprise in health care: Promoting organisational autonomy and staff engagement. London: The King's Fund.

Allen P, Keen J, Wright J, Dempster P, Townsend J, Hutchings A, Street A, Verzulli R (2012). Investigating the governance of autonomous public hospitals in England: multi-site case study of NHS foundation trusts. Journal of Health Services Research Policy. 2012 Apr;17(2):94-100.

Anand, Paul, Mark Exworthy, Francesca Frosini and Lorelei Jones (2012). Autonomy and improved performance: lessons from an NHS policy reform. Public Money and Management, May 2012.

Appleby, John (2011) "NHS Spending; the numbers keep changing" http://www.kingsfund.org.uk/blog/nhs_spending.html. Viewed 29 May 2012.

Appleby, John, Rowena Crawford and Carl Emmerson (2009) *How cold will it be?* London: King's Fund and Institute of Fiscal Studies.

Appleby, John and Chris Ham (2010) *Improving NHS productivity; More with the same not more of the same*. London: King's Fund.

Arrow, Kenneth (1963). Uncertainty and the welfare economics of medical care. American Economic Review, Vol 53:941-973.

Atkinson, Anthony (2005) *Atkinson Review Final Report: Measurement of Government output and productivity for the National Accounts*. London: Office for National Statistics.

Audit Commission (2001) *Acute Hospital Portfolio-Day Surgery*. London: Audit Commission.

Audit Commission (2009) *PbR Data Assurance Framework 2008/09*. London:Audit Commission.

Audit Commission (2011) *Assure: Payment by Results data assurance framework update*. London: Audit Commission.

Bauer, Martin and George Gaskell (2000) *Qualitative Researching with Text, Image and Sound.* London: Sage Publications.

Bechhofer, Frank and Lindsay Patterson (2000) *The Principles of Research Design in the Social Sciences*. London: Routledge.

Berwick, Donald *(2005)"*Measuring NHS Productivity" *British Medical Journal* 330:975-6.

Bevan, Gwyn, and Christopher Hood (2006) "Have targets improved performance in the English NHS?" *British Medical Journal,* 332:419-22.

Blackler, Frank (2006) "Chief Executives and the Modernisation of the English National Health Service" *Leadership,* Vol.2, No. 1, 5-30.

Bloom, Nicholas, Carol Propper, Stephan Steiler and John Van Reenen (2011) *The impact of competition on management quality: evidence from public hospitals*. CEP Discussion Paper No 983: London School of Economics.

Bosanquet, Nick, Henry de Zoete and Emily Beuhler (2005) *The NHS in 2010: Reform or Bust*. London: Reform.

Bridson, John and Bertil Damato (2010) "Consent to rapid treatment of eye tumours: is the waiting time too short at Liverpool Ocular Oncology Centre?" *Clinical Ethics,* June 2010 5:86 94.

Burgess, Simon, Carol Propper and Deborah Wilson (2005) *Will more choice improve outcomes in education and health?* Bristol: The Centre for Market and Public Organisation.

Burns, Lawton and Ralph Muller (2008) "Hospital physician collaboration: landscape of economic integration and impact of clinical integration" *The Milbank Quarterly,* Vol 86(3), 375-434.

Cadbury, Adrian (2002) *Corporate Governance and Chairmanship*. London: Oxford University Press.

Care Quality Commission (2009) *CQC Enforcement Policy*. London: CQC.

Collaborative Communities (2012) "Examples of public sector outsourcing"http://www.collaborativecommunities.org.uk/english/socialenterprise/sandwell.html?searched=sandwell&advsearch=oneword&highlight=ajaxSearch_highlight+ajaxSearch_highlight1. Viewed 14th May 2011.

Cooper, Zachary, Alistair McGuire, Simon Jones and Julian Le Grand (2009) "Equity, waiting times and NHS reforms: retrospective study" *British Medical Journal,* 339:b3264.

Crilly, Tessa and Julian Le Grand (2004) "The motivation and behaviour of hospital Trusts" *Social Science and Medicine*, 2004 May; 5 8 (10):1809-23.

Crosthwaite, Jim, Neil MacLeod and Bill Malcolm (1997) "Case studies:theory and practice in natural resource management" *Paper to Australian Association of Social Research Conference*, Waga Waga.

Dawson, Diane, Maria Goddard and Andrew Street (2001).Improving performance in public hospitals : a role for comparative costs? Health Policy, 57 (2001) pp 235-248

Day, Patricia and Rudolf Klein (2005) *Governance of Foundation Trusts*. London: Nuffield Trust.

Department of Health (1990) *National Health Service and Community Care Act 1990*. London: DoH.

Department of Health (2000) *The NHS Plan : a plan for investment , a plan for reform*. London:DoH.

Department of Health (2002) *Delivering the NHS Plan*. London: DoH.

Department of Health (2003) *Health and Social Care (Community Health and Standards) Act 2003*. London: DoH.

Department of Health (2004) *Quality and Outcomes Framework*. London: DoH.

Department of Health (2010) *Payment By Results Guidance for 2010-11*. London: DoH.

Department of Health (2010) *Equity and Excellence: Liberating the NHS*. London: DoH.

Department of Health (2012) "Statistical press notice NHS referral to treatment waiting times data December 2011 and annual statistical report 2011 "http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_132677.pdf. Viewed 20th February 2012.

Devlin, Nancy and John Appleby (2010) *Getting the most out of PROMS*. London: King's Fund and Office of Health Economics.

Dismuke, Clara and Vania Sena (1999) "Has DRG payment influenced the technical efficiency and productivity of diagnostic technologies in Portuguese public hospitals?" *Health Care Management Science 2* (1999) 107-116.

Dixon, Anna, Tony Harrison and Claire Mundle (2011) *Economic regulation in health care. What can we learn from other regulators?* London: King's Fund.

Dixon, Anna and Julian Le Grand (2006) "Is greater patient choice consistent with equity? The case of the English NHS" *Journal Health Services Research Policy*, vol. 11 no. 3 162-166.

Dixon, Anna, John Storey and Arturo A Rosete (2010). Accountability of foundation trusts in the English NHS: views of directors and governors. Journal of Health Services Research Policy. 2010 Apr; 15(2):82-9. Epub 2010 Feb 10.

Dixon, Jennifer, Julian Le Grand and Peter Smith (2003). Can market forces be used for good? London: The King's Fund.

Edwards, Brian and Margaret Fall (2005) *The Executive Years of the NHS: The England Account 1985-2003*. London: Nuffield Trust.

Farrar, Shelley, Deokhee Yi and Sean Boyle (2011) "Payment by Results" in Mays N, Dixon A, Jones L (eds) Understanding New Labour's market reforms of the English NHS. London: The King's Fund pp66-77.

Farrar Shelley, D Yi , M Sutton , M Chalkley , J Sussex , A Scott (2009). Has payment by results affected the way that English hospitals provide care? Difference-in-difference analysis. BMJ 2009 Aug 27;339:b3047. doi:10.1136/bmj.b3047.

Ferlie, Ewan, Lynn Ashburner, Louise Fitzgerald and Andrew Pettigrew (1996) *The New Public Management in Action*. Oxford: University Press.

Flynn, Norman (2009) *Public Sector Management (5th Edition)*. London: Sage.

Foot, Catherine, Lara Sonola , Jo Maybin and Chris Naylor (2012) *Service-line management. Can it improve quality and efficiency?* London:King's Fund.

Foundation Trust Governors Association (2010) *Hospitals Under Presssure:Essential Brief 12*. London: King's Fund.

Francis, Robert (2009) *Final Report of the Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust*. London: DoH.

Gaynor, Martin, Rodrigo Moreno-Serra and Carol Propper (2010) *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service*. NBER Working Paper 16164.

Getzen, Thomas (2004) *Health Economics, Fundamentals and Flow of Funds*. New York: Wiley.

Ginsburg, Paul and Joy Grossman (2005) *"*When the price isn't right: How Inadvertent Payment Incentives Drive Medical Care" *Health Tracking*, W5-376-384.

Goes, James and ChunLiu Zhan (1995) "The effects of hospital-physician integration strategies on hospital financial performance" *Health Service Research,* 30(4), 507-30.

Hansen, Emily (2006) *Successful Qualitative Health Research*. London: Open University Press.

Graham, Alison and Jane Steele (2001). Optimising Value:The Motivation of Doctors and Managers in the NHS. London: Public Management Foundation.

Ham, Chris (2014). Reforming the NHS from Within. Beyond hierarchy, inspection and markets. London: The King's Fund.

Higgins, Joan, Donna Bradshaw and Kieran Walshe (2005) *The developing role of strategic health authorities: summary report*. Manchester: Manchester Business School.

Holloway, Immy (2005) *Qualitative Research in Health Care*. London: Open University Press.

Humphrey, Charlotte and Jill Russell (2004).Motivation and the values of hospital consultants in south-east England who work in the national health service and do private practice. Social

Science & Medicine, 59 (2004)1241-1250.

Hurst, Jeremy and Sally Williams (2012) *Can NHS hospitals do more with less?* London: Nuffield Trust.

Jha, Ashish and Arnold Epstein (2010). Hospital governance and the quality of care. Health Affairs, 29(1) (2010)pp182-7.

John Lewis (2010) "Annual Report and Accounts" http://www.johnlewispartnership.co.uk/content/dam/cws/pdfs/financials/annual%20reports/John_Lewis_Partnership_annual_report_and_accounts_2010.pdf. Viewed 6th April 2011.

Kerlinger, Fred (1979) *Behavioural research*. New York: Holt, Rinehart and Winston.

King's Fund (2006) *February Briefing.* London:King's Fund.

Klein, Rudolf (2001) *The New Politics of the NHS (4th Edition)*. London: Pearson Education Limited.

Kvale, Steiner (1996) *InterViews*. California: Sage Publications.

Leatherman, Sheila and Kim Sutherland (2005) *The Quest for Quality in the NHS*. London: Nuffield Trust.

Lee, Phillip (2004) "Public Service Productivity: Health" *Economic Trends,* 613 December 2004.

Le Grand, Julian (1999) "Competition, Cooperation, or Control?" *Health Affairs*, vol. 18 no 3, 27-39.

Le Grand, Julian and Will Bartlett (1993) *Quasi Markets and Social Policy*. Basingstoke: Macmillan Press.

Le Grand, Julian, Nicholas Mays and Jo-Ann Mulligan (1998) *Learning from the NHS internal market:a review of the evidence*. London: King's Fund.

Lewis R, Hinton L.? Citizen and staff involvement in health service decision-making: have National Health Service foundation trusts in England given stakeholders a louder voice. Journal of Health Services Research Policy, 2008 Jan;13(1):19-25.

Lipsey, Richard (1987) *Introduction to Positive Economics*. London: Weidenfeld and Nicolson.

Machell,Sue, Pippa Gough and Katy Steward (2009) *From Ward to Board*. London: The King's Fund.

Marquand, David (2004). Decline of the Public: the Hollowing Out of Citizenship.Cambridge:Polity Press.

Pollock, Allyson (2004).NHS Plc: The Privatisation of Our Healthcare. Bath:The Bath Press.

Mathie, Antonina (1997). Doctors and Change. Journal of Management in Medicine,Vol 11 No 6, pp 342-356.

McGlynn, Elizabeth (2009) "Measuring Clinical Quality and Appropriateness" in Peter Smith, Elias Mossialos, Irene Papanicolas and Sheila Leatherman, eds. *Performance Measurement for Health System Improvement.* Cambridge;University Press.

McGuire, Alistair, John Henderson and Gavin Mooney (1988) *The Economics of Health Care*. London: Routledge & Kegan Paul.

McGuire, Alistair and John Van Reenen (2003). Developing new approaches to measuring and understanding outputs and productivity non -published commentary.

McGuire, Alistair and John Van Reenen (2005) "Election Analysis. Health Care: Evidence on the Impact of Increased Spending and Patient Choice "http://eprints.lse.ac.uk/4670/1/Health_Care_Evidence_on_the_Impact_of_Increased_Spending_and_Patient_Choice.pdf. Viewed 3rd May 2005.

McKee, Martin and Judith Healy (2003) *Hospitals in a changing Europe*. Buckingham: University Press.

McPake, Barbara, Lilani Kumaranayake and Charles Normand (2002) *Health Economics: An International Perspective*. London: Routledge.

Modernisation Agency (2004) *Ten High Impact Changes*. London: DoH.

Mooney, Gavin (2003) *Economics, Medicine and Health Care*. Harlow: Prentice Hall.

Monitor (2004) "University College London Hospitals Terms of Authorisation General Condition 2" . http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-

foundation-trust-directory/university-college-london-hospitals-. Viewed 23rd December 2011.

Monitor (2009a) *Letter from William Moyes (Executive Chairmen Monitor) to Board of Directors Basildon and Thurrock University Hospitals NHS Foundation Trust dated 26th November 2009*. London: Monitor.

Monitor (2009b) "May 2009 Board Minutes, Monitor" http:// www.monitornhsft.gov.uk/home/searchresults?search=may+2009+board+minutes&searchtype=all. Viewed 1st Janaury 2012.

Monitor (2010) *Monitor's response to the DoH's consultation on the de-authorisation of NHS foundation trusts*. London: Monitor.

Monitor (2011a) *Compliance Framework 2011/12*. London: Monitor.

Monitor (2011b) "List of NHS Foundation Trusts by authorisation date (1st April 2011)" http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory?letter=AllFT. Viewed 20th February 2012.

Monitor and Frontier (2009) "Measuring Monitor's Impact-Economic Evaluation Report" http://www.monitor-nhsft.gov.uk/home/search-results?search=monitor+and+frontier+report&searchtype=all. Viewed 13th March 2010.

Morrisey, Michael, Frank Sloan and Joseph Valvona (1988) "Shifting Medicare Patients Out of Hospitals" *Health Affairs*, 7, no.5 (1988):52-64.

Nantha, Yogarabindranath Swarna (2013). Intrinsic Motivation:how can it play a pivotal role in changing clinician behaviour? Journal of Health Education and Management, Vol 27 No 2, 2013 pp266-272.

National Audit Office (2008) *NHS Pay Modernisation: New Contracts for General Practice Services in England*. London: NAO.

National Audit Office (2010) *Management of NHS hospital productivity*. London: NAO.

Nolte, Ellen, and Martin McKee (2004) *Does Health Care Save Lives?*. London: Nuffield Trust.

Office for National Statistics (2009) "Total Public Service Output and Productivity[online] "http://www.statistics.gov.uk/articles/nojournal/TotalPublicServiceFinalv5.pdf. Viewed 4th May 2011.

Office for National Statistics (2011) *Public Service Output, Inputs and Productivity*: *Healthcare.* London: ONS.

Parsa, Ali (2011) "Circle signs historic Hinchingbrooke contract" http://www.circlepartnership.co.uk/about-circle/media/circle-signs-hinchingbrooke-nov-11. Viewed 30th November 2011.

Pathiraja, Fiona and Kate Drysdale, (2010) "Galvanising the future of clinical leadership" http://www.hsj.co.uk/resource-centre/best-practice/galvanising-the-future-of-clinical-leadership/5015685.article. Viewed 14th February 2012.

Patton, Michael (2002) as stated in Holloway, Immy (2005) *Qualitative Research*. London: Open University Press.

Pinker, Robert (2006) "From Gift Relationship to Quasi-markets: An Odyssey along the Policy Paths of Altruism and Egoism" *Social Policy and Administration*, Vol. 40, No.1, Feb 2006, p 10-25.

Pritchard, Alwyn (2001) *Measuring productivity in the provision of public services*. London: Office for National Statistics,

Propper, Carol, Deborah Wilson and Simon Burgess (2006). Extending Choice in English Health Care: The Implications of the Economic Evidence. Journal of Social Policy, Vol 35, pp 537-557.

Roberts, John (2004) *The Modern Firm*. Oxford: University Press.

Smith, Ian (2007) *Building a world class NHS*. Basingstoke: Palgrave Macmillan.

Steinwald, Bruce and Laura Dummit (1989) "Hospital Case Mix Change: Sicker Patients or DRG Creep?" *Health Affairs* 8:2 (Summer), 35-47.

Steele, Jane (1999). Wasted Values: Harnessing te Commitment of Public Managers. London: The Public Management Foundation

Street, Andrew (2000). Confident about efficiency measurement in the NHS? Health Care

UK, Spring 2000, pp 47-52.

Talbot-Smith, Alison and Allyson Pollock (2007) *The New NHS A Guide*. London:Routledge.

Turner, Adair (2010) *The Turner Review: a regulatory response to the global banking crisis*. London: Financial Services Authority.

Walshe, Kieran (2003) *Regulating Healthcare*. London:Open University Press.

Yin, Robert (2003) *Case Study Research-Design and Methods*. California: Sage Publications.

APPENDIX ONE

EXAMPLE DOCUMENT SEARCH RESULT

Occurrence Context		**September 07**
Word/Phrase		
(PbR) Payment by Results		Nil
Productivity		Nil
(SLE) Service Line Economics/Reporting/Management	1	1.Monitoring performance against key objectives
Cost Control		Nil
Quality/ **Measuring quality**	2	**1** Strategic objective -improving quality of patient care **2** productive wards -*enabling innovation, excellence and ongoing quality improvement by financially responsive actions*
Financial Balance/ **Management**		Nil
Efficiency	2	**1** 7 key strategic objectives: improving efficiency **2** *monitor*

Page 2

Monitor	8	**1** Chairman attended dinner hosted by Monitor Ex Ch **2** *Monitor doc on managing operating cash in FTs* ***3****. Code of Governance-duty to co-operate*

		4 NED terms of office comply with Monitor Code **5** Board noted Monitor's Review of 07/08 annual plan **6** *Board noted Monitor's analysis of Q1 performance* **7** IA report on compliance with Monitor's Code of Governance **8** *Monitor's review of FT Sector Annual Plans 07/08*
Maximise income/ revenue/ output		Nil
Reduce Costs		Nil
(CIP) Cost Improvement Plan		Nil
Length of Stay/LoS		Nil
Tariff		Nil
(RCI) Relative Cost Index		Nil
(VFM)/Value for Money		Nil
Patient Choice		Nil
Choice		Nil
Competition		Nil

APPENDIX TWO

EXAMPLE BOARD MINUTE RESULT

BOARD MINUTE KEY

Elements shaded RED indicate positive search result including context

XXX indicates deletions to protect anonymity

1 of 12

MINUTES OF THE X MEETING OF

THE BOARD OF DIRECTORS OF THE

X FOUNDATION TRUST

PRESENT:

APOLOGIES:

IN ATTENDANCE:

380.07 DECLARATION OF INTERESTS

There were no new notifications of interest.

381.07 CHAIRMAN'S REMARKS

The Chairman welcomed X the Acting Director of Operations, with effect from 1st October to the Board meeting and wished X good luck for her secondment in X.

She asked if procedurally all questions could be placed through the Chair and that she intended to increase the pace of Board meetings in the light of the large agendas the Board were now facing.

382.07 CHIEF EXECUTIVE'S VERBAL REPORT

X reported the following:

a) She had attended a dinner hosted by Dr Bill Moyes (Executive Chairman of Monitor) at which)XXXXXXXXXXwas present. In discussion it was apparent that the Government viewed FTs as a successful part of the NHS organisation and that for the future there would be a focus on a drive towards public health and improving the general health of the population. There had been interesting discussion about secondary care providers delivering care closer to patients' homes. XXX will be invited to visit the local area at some stage in the future.

b) The Trust was meeting with the Healthcare Commission on XXX September to receive feedback on their review of performance in meeting

healthcare standards.

c) On XXXX Lord XXXX would be visiting the Trust, together with XX David Nicholson the NHS Chief Executive, as part of his review of the NHS. Much work nationally had been undertaken towards the Darzi review focusing especially on clinical staff engagement. She also reported that the emerging national strategy appears to mirror our own revised strategic directions, which was good in that it would reduce any potential tensions within the organisation in the future. It would also provide a firm foundation on which we could build relations with our stakeholders.

382a.07 The Chairman asked Mr X to report on his attendance at a King's Fund meeting where he had represented the Chairman. He reported that the discussions had centred on the potential role of the Foundation Trust Governors Association where it had been suggested that one role might be to lobby Government. There was concern at this as it was not widely viewed as the governors' role. In general, the feeling was that the governors' role in relation to FTs is unclear and needs clarification.

383.07 MINUTES OF THE LAST MEETING

The minutes of the Board of Directors meeting held on Wednesday X were approved as a correct record.

384.07 MATTERS ARISING &BOARD ACTIONS SUMMARY CHECK

a) Review of the Action Grid.

279/07 (Patient Pathway complexities) Complete. A briefing paper had been prepared and would be issued shortly.

358/07 (Rises in ED activity) Complete. A response was included within the performance briefing for this month.

359.07 (Amendment of Infection Control Report) Complete.

b) Matters Arising

378/07 (MTAS). X reported that the August hand over went well finally and no X doctors were without jobs. However, next year may be more problematic.

370/07 (Revised Complaint Policy). X reported that changes had been made to the Complaints Policy as discussed at the July Board meeting.

Mr X reported on the issue of a document from Monitor concerning managing operating cash in FTs. He requested a short statement from the Finance Director on how our cash holdings are invested and whether they are in line with Monitor's recommendations. He was concerned that if they were not, it could affect our financial risk rating in the future. X replied that this information would be included in his review of financial information coming to the Board.

Action: X

Mr X added that the Board needed to be assured that no unnecessary risks were being taken with investment. Mr X confirmed that this was the case.

385.07 STRATEGIC INVESTMENT FUND – PROPOSALS FOR INVESTMENT 2007/08

X introduced this report by reminding the Board that the Annual Plan included proposals to create a fund for re-investment purposes which were to be appropriately allocated. Clinicians and managers throughout the Trust had been consulted and asked how the money should be re-invested to achieve key strategic objectives and the results of these discussions were now presented to the Board for approval. The Executive Directors had reviewed the proposals and all that were considered appropriate were set out in the paper.

X then reported on the financial background. The Trust was now operating on a financially sound financial basis and £3-4m had been identified for re-investment in the current year. However, he stressed that items to be included were largely of a non-recurrent revenue nature for this year as the resources were

already taken into account in meeting future expenditure from 2008/9. A small number of recurrent items (i.e. under £500k) could be approved but these would inevitably form a pre-commitment on next year's funding. Criteria for inclusion in the investment fund were that:

• Proposals should be aligned to the emerging Strategic Directions

• Priority given to the top 5 priorities identified by members of staff and membership

• Schemes must be completed before the year end

• A maximum of £500k is available for recurrent revenue commitment in the next financial year

• Proposals must aim at delivering significant benefits to large numbers of staff and patients.

Proposals from Directorates had been reviewed and prioritised against the 7 key strategic objectives; namely:

• Improving quality of patient care

• Eliminating avoidable infections

• Improving patient safety

• Improving the environment for patients and staff

• Improving staff developments and welfare

• Reducing waiting for patients

• Improving efficiency

X explained that the allocation of £54k for reducing waiting for patients appeared low but was not the full extent of funding as significant additional funds for meeting the 18 week referral to transfer target were also available. Therefore this initiative did not need as much assistance from the strategic investment fund. The same situation related to funds allocated to avoiding infections where further earmarked funding had been provided by the DH.

X viewed this fund as a very positive message to the Trust by providing visible evidence of the Trust's intention to invest in services once stringent financial targets had been met. X confirmed that he would investigate how this exercise may be repeated in future years.

One of the largest investments was the intention to replace all the beds in the hospital with new state of the art electrical beds. This will have a hugely positive impact for patients and staff alike. The list includes many items submitted by

individual Clinical Directors reflecting the priorities for their departments and he commended it to the Board.

Miss X added that a further £220k was available from the Strategic Health Authority towards infection control.

Mr X fully supported the thrust of the report but was concerned that some of the spending would be seen as investing in the infrastructure and not strategic investment. Mr X agreed but added that some areas needed attention and it was not possible to meet all the requirements in this area from in-year funds. X also agreed but stated that there was a need to catch up on infrastructure work in some areas, particularly with regard to the ongoing redecoration programme.

The Chairman summarised that this is a one-off opportunity at present to do things which had been left out in the past. Bids for funding that had not been prioritised were valued at less than £250k and were mainly funded from elsewhere.

X supported the idea of the fund but made the following points:

• Funds available for investment were substantial – in the order of £40m and he felt that there must be protocols for both their investment and reporting to the Board. It would always be a problem to decide what to do with such funds and he felt that a set of 'rules/criteria' was necessary to ensure even-handedness in dealing with the various bids

• He asked whether the covered walkway from E link corridor to the northern end of the site would be replaced as it was an eye-sore. In response. it was stated that there was no current plan to replace this walkway as although it may not look very cosmetically attractive it was functional. The question could be readdressed when future capital programmes were considered.

X asked whether our surplus would cover any risk if the PCT was unable to pay the contractual sums it might owe the Trust in the future. X considered this should not be a problem as the PCT had a funding capacity for this and the Trust also has a small contingency set aside. He also asked about the potential shortfalls against planned budget in some of the Directorates and how this would be dealt with. X responded by saying that 3 Directorates had forecast an overspend this year and the end of year forecast figures included this possibility of such an overspend.

The Chairman asked X if he felt that the financial assumptions upon which the Trust was operating remained robust which X confirmed.

Mr X asked whether this was an opportunity to involve governors by linking with members on this matter. It was agreed that the newsletter and constituency meetings would be used to reinforce this initiative.

The Board noted this report and approved the list of areas for investment.

386.07 RELEASING TIME TO CARE – PRODUCTIVE WARD

Miss X gave a presentation on this topic which is part of a national programme aimed at increasing the time that nurses have available to spend on direct patient care. It focused on ward teams and their processes and systems. Nationally, the programme has been successfully piloted on 1 ward in 4 different hospitals. This

pilot programme is now being rolled out to 10 further hospitals although the X had not been not successful in a bid to represent the XXX. However, there is great enthusiasm to take this forward within the X alongside the national programme.

The main principles underpinning releasing time to care initiative reflect a number of objectives already outlined in the X strategic objectives, including:

• Delivering care to a consistently high standard

• Delivering services in an environment which is comfortable and friendly to patients

• Reducing hospital acquired infections

• Enabling innovation, excellence and ongoing quality improvement by financially responsive actions.

The paper proposed that the Director of Nursing & Service Improvement would take responsibility as the executive lead for the project, which would be co-ordinated by the X Service Development Team.

The outcome of the project would be to:

• Increase the clinical time spent face to face with patients

• Enable safer and more reliable care

• Improve the experience of staff and patients

• Organise wards to work more efficiently

• Reduce interruptions and improve communication
• Reduce the time taken in handovers
• Ensure clear lines of accountability
• Limit interruption during medicine rounds thereby allowing their safer administration.

It was stressed that this project was not about reducing the number of nurses.

Funding costs were expected to be £45k for this financial year and had already been approved as one of the strategic investment fund allocations. This would allow staff to:
• Complete relevant training
• Review current systems and processes
• Implement appropriate changes
• Evaluate results
• Present results
• Disseminate learning

In addition, a sum of money would be made available to enable rapid implementation of any initiatives to facilitate changes without having to delay the process by going through a more bureaucratic directorate process.

Mr X asked how you would ensure that the 'freed' time actually was spent on patient care and how it would be measured. Miss X reported that would have to be part of the ongoing work of the project to ensure that this occurred.

Mr X asked whether there was training programme to help nurses make better use of their time. Miss X replied that there was no specific one but some techniques like videoing activities helped in this respect.

6 of 12

The Chairman was enthusiastic in her support for this initiative to help people work in a more efficient manner, which would ultimately be more rewarding.

The Board noted the report and endorsed the introduction of the Productive Ward initiative across the X.

387.07 PLANNING & PERFORMANCE FRAMWORK

Mr X reported that this was an attempt to pull together the integrated nature of all our strategic planning processes in one unified process which neatly dovetailed within its constituent parts and was delivered on time in accordance with an annual cycle. Currently planning and performance processes were not fully integrated and this leads to some fragmentation. The framework would encompass many key elements including such items as the Trust's Strategic Directions, Operational Plans, the Annual Plan and a number of efficiency and service development programmes. It was based on a cyclical process running throughout the year which started with the review of the Trust's Strategy; a review of both national and local commissioning requirements leading to the production of short-term plans and performance targets and budgets. There would be consistent monitoring of performance towards meeting key objectives throughout the year. Mr X wished to introduce this framework concurrently with the new Trust Strategy in October 2007. The Service Line Management model being introduced across the Trust already provided a basic process to follow and the Trust business planning framework would mirror the 5 business case model used widely in the public sector. This included:

• Pre-strategic outline case
• Strategic outline case
• Outline business case
• Full business case
• Post implementation review

A key part of this cyclical process is to identify the involvement required from the Trust Board and the report recommended an annual timetable of Board involvement.

The Chairman acknowledged that there would be a lot of hard work required in implementation of this framework and asked whether the benefits would justify the resource costs. Mr X replied that he believed that it would, providing the framework was not made too complicated.

X added that most of the constituent parts envisaged in the framework were already being done and the overall process needed streamlining, in order to allow a more systematic approach to be developed. She saw this as an iterative process which must enhance decision-making, and not just be a bureaucratic exercise.

Mr X endorsed the idea saying that it would provide a total picture for the Board on how to manage change.

The Chairman added that she would be working with X and the Board Secretary to include the requirements of this framework into the Board business cycle in a sensible way.

Action: X

She concluded by thanking and congratulating everyone who had been involved in the development of the framework so far.

The Board approved the introduction of the Planning and Performance Framework.

388.07 PERFORMANCE REPORT

X reported that the Trust was meeting all the key Healthcare Commission standards and targets and highlighted the following issues:

• Performance against the 62-day cancer target had fallen for July 2007. However recalculation of performance by the Healthcare Commission now indicated that the Trust had met the target. The numbers involved were very small, just 4 out of 54 patients; and therefore any delay to a patient had significant effects on the percentage performance figure.

• She advised the Board that the Trust had been asked by the PCT to agree revised interim targets working towards the 18 week referral to treatment target. The Trust had responded by saying that it would do its best to meet this request.

• There had been only 1 case of hospital acquired MRSA in the last 3 months.

• Emergency Department activity. It had been assessed that the number of Walk-in Centre patients which was increasing and generating the additional activity in ED. (refers to Action Grid – Minute 358/07)

• C.diff infections. The Healthcare Commission had confirmed the data requirement for this year which the Trust was submitting.

Delayed transfers of care. The Trust was in discussion with the PCT about how systems could be improved, to ensure that patients are cared for in the most suitable setting.

• C.diff infections. The age range for reporting C diff infections had been

increased this year to include everyone over 2 years old as opposed to those over 65 years old. This had increased the Trust's rate of infection from 1.47 per 1000 bed days to 2.19 in the final quarter of 2006/07. Despite this, the Trust's level of infection were still less than the national and regional average, however, it may prove difficult to achieve the agreed local PCT target of <1.47 infections per 1000 bed days.

The Board noted the Performance Report.

389.07 COMPLAINTS REPORT QUARTER 1 2007/08

X reported that there had been a total of 80 formal written complaints received during Q1 and 10 requests relating to losses and compensation. Formal written complaints represent less than 0.07% of overall patient activity within the Trust equating to 1 formal written complaint for every 1420 episodes. The number of commendations received, although slightly decreased on the previous quarter, was at a ratio of 19 commendations to every 1 complaint.

98% of complaints were responded to within 25 working days. There were no identifiable trends in any of the complaints received, although there were rises in the number of complaints surrounding 'access and waiting' and 'clean, comfortable safe place to be' categories.

X went on to explain that a consultation process was ongoing suggesting new changes to NHS (Complaints) Amendment Regulations 2006. The consultation process is due to end in October 07 and the X will need update its

internal processes accordingly. These proposals would place far more importance on rigorous local resolution of the complaint and the option for a complainant to ask for an independent review would disappear. This would include greater use of meetings and mediation, and the new processes would require close co-operation between complaints, PALS and claims departments.

With regard to reporting complaints activity to the Board she requested approval to form a sub-group to review this and recommend a revised reporting procedure. She requested the inclusion of a Non-Executive Director. In her absence it was considered that perhaps X may be interested in joining this group. Mr X also indicated his willingness to be involved in this group. The Board discussed how the views of governors could be considered as part of the review and the Chairman suggested that they should be involved by means of a joint development session at some stage.

Acton: X

Mrs X asked whether the new system of complaints would overcome the problem of vexations complainants. Miss X felt it would probably not achieve this but it may help those complainants who had less confidence in the complaints system.

The Board noted the content of the report and agreed the proposals to form a working group to review the complaints reporting procedure.

390.07 FINANCE & ACTIVITY REPORT

X reported a satisfactory financial position for the Trust which was now predicting an end of year surplus figure of £0.4m ahead of plan. Liquidity remained ahead of plan and the financial risk rating was assessed at 5

He referred to some potential areas of concern namely;

• Currently the Trust was £1m under its income target for the year, mostly due

to a shortfall in elective activity against plan. However, he expected this to pick up on account of increased activity to meet the 18 week referral to treatment target.

• Underachievement of CRES was estimated to be £2m across all Directorates for the year. Discussions were taking place with Directorates in order to improve the situation.

• 3 Directorates were forecasting an overspend. Work continues with these Directorates to achieve a balanced position by the year end.

X added that there was a degree of concern nationally about the amount of FT surpluses being generated which were not being reinvested in service improvement. The creation of the strategic investment fund demonstrated the Boards intention to re-invest in services for the benefit of patients.

X fully supported the creation of the Strategic Investment Fund (SIF).
He agreed that capital expenditure should be included in it, and, for the first year of its existence, some revenue expenditure. Thereafter, he felt that revenue expenditure should be in the Trust's operating budget and not the SIF.
Mr X asked if future reports could show variance on the cost of capital projects against total planned expenditure and X agreed to include this in his review of how financial reporting was reported to the Board. Mr X also asked

about impairment and what might be the expected outcome of the forthcoming review of land and property revaluation. X replied that the likely outcome was unclear as the trust was currently engaged with the District Valuer in a whole hospital 5-year revaluation process.

Activity.

Activity in overall terms was lower in August than in July but higher than in August 2006. The forward order book (outpatient activity) was 25% lower than July and 9% below the level in August 2006. Elective inpatient activity is slightly lower in August than July but at the same level as August 2006. Elective day cases were slightly lower than July but 23% higher than August 2006. Non-elective activity levels have deceased since July but were running 3% higher than August 2006.

In conducting his review of how financial performance was reported to the Board X stated that he intended to issue a questionnaire to Board members this month and would then form a review group to review the results of this survey on proposed recommendations later in the year.

The Board noted the Finance and Activity Report.

391.07 GOVERNANCE ANNUAL REPORT 2006/07

Mr X presented this report for last year and highlighted the following key achievement:

• Ongoing development of the Assurance Framework allowing another full statement on internal control to be signed

• Further development of a Trust-wide system to monitor and collate evidence against all core healthcare standards allowing internal audit of each standard with a positive sign-off

• Further development of the Trust's Risk Register covering all areas of the Trust

• Directorate governance groups operating in all areas

• Continuing increase in the number of staff who attended detailed risk management training

• Implementation of the Health and Safety Action Plan

• Successful outcome of the Health and Safety Executive inspection

• Compliance with the National Patient Safety Agency Alert notices

• Uploading all patient safety incidents to the NPSA reporting system

• More robust and proactive dissemination of risk management information

• Embedding random note reviews into Directorate audit work streams

• Work on priority national clinical audits to ensure that the Trust takes part in all nationally agreed clinical audits

• Development of the national Institute for Health and Clinical Excellence guidance tracking system

• Continued development of the integrated care pathways with specific regard to the single assessment process

• Further development of user involvement monitoring systems.

Mr X referred to a meeting the Non–Executive Directors had held with a neighbouring NHS Trust where it had been suggested clinical governance was a clinical directorate responsibility. X confirmed clinical directorates were a key part of the trust's governance structure and formed part of the assurance

10 of 12

process the Board had in place to ensure effective and embedded systems. X commented statutory responsibility for clinical governance rested with the Chief Executive and it could not be devolved.

In discussion, it was agreed that Non-Executive Directors should be given a further briefing by the Governance Manager on the governance systems in place and their role in the overview of the governance structure. A future NED meeting would be an appropriate vehicle for this.

Action: XX

X added that he had found the Governance Committee to be very committed to its task and that the culture surrounding governance had improved greatly across the Trust. As the Deputy Chair of the Governance Committee, he was extremely satisfied with the governance structure in place.

It was noted that in Para 4.1.1, fourth sentence, the reference to the Vice Chairman of the Board chairing the Committee was wrong and this would be amended by Mr X.

Action: XX

The Chairman asked how the NSF working parties reported. X replied that this was done via the Directorate structures. Miss X drew the Boards attention to the NSF element of the Directorate briefing reports that were prepared for the Board/clinical directorate briefing meetings.

The Board received the Governance Annual Report 2006/07, noted the progress made to date and approved the Health and Safety Action Plan and the Clinical and Cost Effectiveness Plan for 2007/08.

392.07 LIST OF THIRD PARTIES WITH WHICH THE TRUST HAS A DUTY TO CO-OPERATE

X introduced this paper which was a requirement of Monitor's Code of Governance, which required that Boards maintained a list of those third parties with which the Trust had a duty to co-operate. The list had been drawn up in consultation with Executive Directors and was now presented for approval. In discussion, it was decided that XXX Trust and XXX Constabulary should be added both of whom would be classed as 'co-operation as required'. It was also noted that the Commission for Racial Equality had now been re-titled The Equality and Human Rights Commission. Mr X would amend the list accordingly.

Action: XXX

The Board approved the list of third parties with which the Trust had a duty to co-operate with the amendments above.

393.07 REVIEW OF POLICY FOR THE COMPOSITION OF NON-EXECUTIVE DIRECTORS ON THE BOARD OF DIRECTORS

Mr X introduced his paper which was a routine review of the policy. In particular, he asked the Board to confirm that the skills and experience categories in paragraph 4 remained relevant. He also stated that paragraph 7 concerning terms of office needed to be amended to align with the recommendations of Monitor's Code of Governance and proposed that this should now read "Terms of Office will be in accordance with the guidance in Monitor's Code of Governance".

11 of 12

The Board approved this amendment and also made one small change to paragraph 4b (Commerce) where "marketing" would be included in the wording. Mr XXX would action these amendments and pass the policy on to the Council of Governors on XX October for their approval**.**

Action: XX

The Board agreed the policy for the Composition of NEDs on the Board of Directors with the amendments noted above.

394.07 MONITOR'S REVIEW OF X ANNUAL PLAN 2007/08

X introduced this document. The Trust's risk ratings for the year were

confirmed as follows:

• Financial - 4
• Governance - Green
• Mandatory Services – Green

She asked the Board to note that the arrangements whereby the Trust had loaned money to the PCT last year were discouraged by Monitor.

The Board noted Monitor's Review of the X Annual Plan 2007/08.

395.07 MONITOR Q1 ANALYSIS OF X PERFORMANCE

X introduced this report. Monitor had confirmed the Trust's risk ratings following analysis of the Trust's Q1 report as follows:

• Financial – 5
• Governance – Green
• Mandatory Services – Green

The Trust continued to operate in the upper quartile of FTs performance.

The Board noted the Monitor Analysis of X Q1 Performance.

396.07 INTERNAL AUDIT REPORT – MONITOR CODE OF GOVERNANCE

Mr X introduced this item which was the first in a cycle of reviews of the Board's compliance with Monitor's Code of Governance. A request for a full review of all 74 code provisions had proved too great a workload for internal audit and it

had been agreed that 15 provisions would be reviewed every 6 months. The report had revealed that the Board is employing a sound system of oversight of the code provisions and that of the 15 provisions reviewed only one (F.3.2) did not comply with the Code. This concerned Audit Committee Terms of Reference and would be addressed as part of the proposed Audit Committee function review later this year.

The Board noted the Internal Audit Report on compliance with the Code of Governance, and agreed to the proposal to include a review of Audit Committee Terms of Reference within the forthcoming review of the Audit Committee function.

12 of 12

397.07 EXECUTIVE LEADERSHIP WALKAROUNDS

X presented this report for information. Executive Directors are committed to regular walkarounds and visits to a variety of areas across the Trust. This is part of a campaign led internationally by the Institute of Health Improvement to increase safety awareness throughout the NHS. It also allowed EDs to directly engage with staff over a number of issues. The report also proposed methods by which the walkarounds should be conducted. Executive Directors have accepted the principles involved already and the first walkarounds started in August 2007. The Board will be kept advised on the success of the initiative as well as any significant findings identified.

The Board noted the report on Executive Leadership Walkarounds.

398.07 MONITOR REVIEW OF FT SECTOR ANNUAL PLANS 2007/08

X presented this paper for information which had been issued by Monitor into the public domain. It showed that the Trust continues to perform in the upper quartile of Acute Trusts.

The Board noted the results of Monitor's Review of FT Sector Annual Plans 2007/08.

399.07 ANY OTHER BUSINESS

There was no further business to discuss.

400.07 DATE OF NEXT MEETING

The next meeting of the Board of Directors will take place on XXXXX.

APPENDIX THREE

EXAMPLE TRANSCRIPT

TRANSCRIPT KEY

Black manuscript-Interviewee

Blue Manuscript-Interviewer

XXX Deletions to protect anonymity

Director of [non clinical] XXXXXXXXXXXX. Before that for about three years I was an orthopaedic General Manager XXXXXXXXXXXX. Before that a corporate manning role for 18 months and before that XXXXXXXXXX, a Service Manager.

Have you always been in the NHS career wise?

Yes for the past 10 years pretty much so.

And before that?

A couple of years out and then university.

OK, very easy question to kick off with. If you're looking at the Trust over the last three years, what do you think it's focussed its main managerial energy.

It's always been very strong performance focussed, which is waiting times, and financial balance and then there's a lot of focus around getting FT status and linked to that is getting 3 stars and then, you know, trying to get reasonable scores in the Health Care Commission, so very strong measurable performance.

And on the performance what was the balance between financial and clinical.

The financial performance has been consistent all the way through. The incredible attention to detail on the waiting list management has slightly declined but there's been a rising Health Care Commission in other quality indicators and we're just coming to our quarterly reviews

with directorates which are actually taking much wider views, so for instance, patient satisfaction, as well as clinical governance, infection control. I think more the growth of other measures that widen the field rather than less on the previous team.

OK, on finance now, if you were to say what the balance was between finance and other indicators – what's the balance do you think?

Partly because the last two years have been largely problem free much more maintenance tasks than major changes so whilst we had a capital programme of about 3 million this year it's not been as dominating an issue.

Just talking about measurement for a little while. If I were to ask you the question 'what are your outcome measures of this Trust, what would your answer be?'

Outcomes is stemming from process measures, where we've got stacks and stacks of process measures of waiting times and things like that so mainly, I think, people tend to focus on clinical outcomes we talked of outcomes per se.

If you make it more generic and said 'outputs' what would they insert then?

Ok, if it was outputs then I think people would start focussing mainly on activity, and I think we have seen a significant increase, particularly over the last year around people, particularly General Managers and some of the more engaged clinicians around PbR and PbB activity and making the link between income and expenditure. Very strong history over ten to 15 years of managing to budget. What we're only just beginning to get our heads around is managing income and expenditure in a way that's slightly more 'real world'

So more sophisticated financial reporting in fact.

And understanding, and there is still a bit of the culture which is partly 'this is my income target and that's it'. There's more work out there or less work out there it doesn't really matter – that's the income target. The Trust corporately will smooth off the differences, and that's partly driven by a couple of factors, one is some big swings in medicine, particularly in emergency admissions going down without the structure being refused. But also a history of a dispute with PCT around what they pay for extra activity, so there's still quite a strong conservative culture around going out and getting income because that's seen as stimulating demand, and seen as not being a partner with the health economy. So it's getting that balance right between entrepreneurial approach to income.

So output measurement is broadly numbers of units produced effectively?

Broadly yes

If we use outcomes then we're going to get more clinical focus.

Yes

At the Board, when you discuss output (including the quality measure) what kind of data is the Board getting on outputs generally?

We do a key performance indicator paper, here, which we've just produced if you would like to have a look! Which is very much on the Monitor key performance indicators which also map across to the Health Care Commissions so very much nationally set and we can add our local one which is our contract so these would be seen as performance indicators so incomes, outcomes or whatever tends to be performance indicators and then 18 weeks because that's the new target and we don't really understand it and we're still working on it da, da, de, da and we're still some way off. And then there's the Health Care Commission new targets which are the ones that feed the Health Care Commission rating we get. That's one set, and we then get the…

And the Board gets this every month?

Yes, the Board gets it every month and will have a bit of focus on different areas and particular issues and so on without the finance papers which will talk about the – in the public section – very limited, a couple – well one page really – of what the headlines are. In part two we have the directorate reports which are very detailed in terms of income activity expenditure, sickness and so on, and those get quite a lot of scrutiny as well but mainly in the Finance Committee. So those are the two big performance indicators, we are going to take a bit of a review of that but those are the main ones.

So you're using in terms of numbers are going to be about your access times and hitting those access times. In terms of the quality indicators are you saying the indicators for StBH is basically your proxy for quality measurement?

Whilst we sign that off every year, and there are pressures beneath that, underneath the Board there's the Governance Mismanagement Committee which gets its own sets of data and there's also the Infections Control Committee – so there's actually quite an active Board sub-committee structure which is where the majority of that will go on. The thing that comes to the Board on a quarterly basis is the Clinical Governance Risk Report which is a really detailed report listing everything from Adverse Incidents Reports through to NICE

Compliance, audits undertaken and that's a pretty large document that comes every quarter. Then we've got Infection Control Annual Plan and quarterly updates.

So there are quality indicators in that. What about value added indicators?

Zero – well let me see – value added indicators – none that we explicitly look at in that way. There's quite a lot on mortality, we score quite low on our mortality index a couple of years back and that's improved significantly and the Medical Director led a large piece of work looking at that part of that was around the fact that we've got a palliative care unit within the Trust, which kind of makes your figures worse, but others were around a couple of areas where we were outlier. So in terms of whether you would call that a value added I'm trying to think…

What I'm getting at is say your ortho ops are doing hips, not many people, hopefully, die through hips but do you have evidence of functionality improvement pre op, post op – is that kind of stuff reported at Board level or…?

No, and it would only be on a pretty exceptional ad hoc basis. Ones that come up through the Health Care Commission we do see, so for instance the Stroke Sentinel Audit is one we looked at quite a lot where we're pretty good on the whole, but quite poor on a few of the 16 standards, or whatever it is. So that's one in particular because stroke is an area where we're beacon leading edge and it is priority of the Board taking an interest in that one. But unless it's coming through, probably one of the Audit Commission or one of those other reports, probably not one of our own self-generated reports. Within the strategy have you seen our Fast Track Reports?

The one you've just been working on? No I haven't read it yet

We're trying to get to the stage of coming out with some slightly smarter measures which we want to achieve against our goals so some of them are rehashes of targets that are well known to us a few are new and one in particular in terms of the contract is just a set of clinical outcome measures – now admittedly we haven't done that yet, but it's in there and it's identified. It's an area where we're pretty poor in having systems to measure outcomes beyond the immediate and also outcomes that are beyond the ad hoc audit. But the biggest push we've had is in developing the Patient Satisfaction Scores is our first piece of work. Once we've got that established…

As I understand it, that's not national work that's your own satisfaction survey

Yes, there's a couple of questions that we track that are the same questions as the national one but we're just trying to get that established as a culture of constantly asking …

Good. So one picking up on one… you started financial focussed?

Financial and Waiting Times, yes

National Agenda - Financial/National Agenda?

Yes

And where you're going now is more the Trust's agenda on quality, how are you going to measure that in a more sophisticated way – is that fair?

Yes, I think we're beginning to… as long as the National 'must do's' are being met, yes we're beginning to get head room to develop into other areas that particularly interest us.

Interesting. OK, just going to PBR now for a minute, if I may. In the background 2004 PBR was introduced what impact do you think PBR itself has had on the Trust, if any?

It's got people thinking quite differently about work, so I think it has had quite a large impact in terms of decision making particularly by Clinical Directors, General Manages and the Board. We almost had a kind of false… sorry, the first year of Foundation Trust status was the first year when we sort of had PBR in place and drifted into a major dispute that effectively blew up in year two so we kind of had a bit of a faltering start as to what the system was because the PCT's view was that PBR was we set a figure of how much we want to spend and you live within that which is different from our interpretation and we went through a very painful process of actually saying 'no it's paying for the work we do. So that kind of resolved last summer so really in many ways the understanding of the system is only developing over the last 12 months I would think, and that's been further confused by 18 weeks were pretty much, if something needs doing, do it – get on with it. So from having had 2 or 3 years of demark and control and trying to manage waiting list outs and various hoops to jump through we're very much now way back the other way and just get on with it, treat it. PCT's in very good financial health, reducing tariff price, 4% growth in the next few years. You see the next few years with PCT's with lots of money demanding price when demand control isn't the issue, it's can we do it at the price? I think people are beginning to understand what PBR is and almost the context in which it is working has changed for us locally in three distinct phases.

Just to pick up your point about the 4%…

Sorry, this is the go forward thing

Oh yes. If you were very clear up to now that the PCT had a budget and it was asking you to do like your job would therefore have been to make your processes as efficient as possible to deliver that activity within the budget. Do you see the PCT with real 4% growth every year for the next three years as removing a constraint on the Trust?

In terms of the mind set of the past 15 years, here's your block of cash, whoever comes through the door you've got to treat. There's a strong incentive there, if we can avoid admissions, if we can drop follow-ups we can reduce demand there's every incentive for us, there's none for the GP to do that. Now, actually that's going to avoid referrals but can we afford to shut the two beds or the wards that will be a consequence of us losing that income, so we're trying to get beyond that immediate knee jerk drawbridge and actually say, well if that money gets reinvested and we can manage in a planned way then it is possible for us to continue this demand management but that's quite a difficult thing to balance. Is the perverse incentives of A system which encourages greater activity because of the income and you build an Empire on the back of that against the PCT clearly not wanting that to happen, and lots of tension that could fall out of that so there's a straightforward income, turnover, volume issue. However there has also been, which I think is the question you were originally asking, looking at our processes, can we do it at tariff, what can we do to reduce our costs and maintain activity or indeed grow activity at the same costs? So we're beginning to get there but it's very uneven .

If I'm saying to you, Richard, next year there's a 4% going in we can probably therefore – if you've got a service that's struggling a bit to break even, does the option now come of well we can trade, get can get more through and spread our fixed costs out and we don't need to look at processes quite so much now because we can trade out way out of the loss?

That's possibly what could happen – it hasn't happened yet but I can see it happening and that will be 'can we do it by taking other Trusts' work, can we just grow the market? So both of those are possible, although I think that again there's an issue that health care isn't the same as many other markets because there probably are only so many hips you can do and whilst thresholds can change there comes a point where any clinicians not… so I think there is some way to go but for instance our cardiology , arrangements are the best in the country well I think there comes a point where there are so many pace makers you can put in da, da, so the only example I can think of where someone has explicitly said we want to grow this because of the financial situation is our maternity unit where it's midwife led – on the largest midwife led units in the country – but still quite small in comparison with most maternity units - and there we've got quite high fixed costs just to run a service and it has declined from about 800 to 500 births over the last few years and is now just beginning to turn back up again and that's something we're very keen to support. So we have a marketing strategy which includes as part of that supporting the maternity unit as part of that area, but we have also identified 17 practices where we get between 30-70% referrals and we deem those to be most significant growth and then transferrals from other Trusts to us – 70% because of our case mix of services is about the right amount. If we get maximum penetration of the services we provide it's about 75%, so getting 70% of a practice's entire practice's , is pretty much total saturation so these are the ones that are next ring geographically – we identify them on geography – but

those are the ones if we can get a switch of 5% to us from other Trusts, would be worth the effort. So there is a growth view point that… so it's slightly more than we can simply grow our way out

I think that's a really good point that 4% growth will change the context in which everyone is operating

And also that taking 2½% efficiency – taking 2½% out of the costs out of the organisation is pretty damn difficult every year, year on year so for the next couple of years saying we're going to meet growth through productivity wise would be possible. PCT don't want to spend more with us and they would like to spend 3% less a year so there's going to be a tension, but if we can do the work and it's there to be done and people come to us then a bit of that and a bit of cash we'll be able to see our way through this.

Interesting. Going back to the PBR for a second. Clearly it's had an impact at Board level, in decision making, what impact has it had on the shop floor? …Consultant kind of delivery, what's the impact of that?

Without stereotyping, there's a very strong distinction between, surgeons and physicians in that surgeons fully understand the market and they, in their private time, and General Managers understand that income has got to be earned and delivered so I think pretty strong impact there. Amongst the physicians it's slightly more difficult because of they're not so much in a competitive field, they're still very much in the mind set if we net work to get away that's a good thing so I think there has been a bit of a distinction by specialty. I think most people at Consultant Senior Manager, level have understood it. We did however run a day a couple of weeks ago on PBR and report it because we felt actually because we've been going at this for three years and a lot of people still don't understand the basics so there is still quite a large education we need to do around the rules of the game, what counts, what's billable, what's not billable and equally we're finding GPs challenging our billing based on no knowledge of how PBR works at all. So I think in clinician's terms there's quite a lot of engagement still to be done, but people can understand the basic business concept that you sell stuff and you buy it and you get paid for it

If we were going to walk out now – lets do the medics first, and kind of 'what's wrong with this patient?' Give the diagnosis, fine and so roughly what's the cost of delivering that and we're going to get a tariff for that, probably not in front of the patient. What do you think the response would be?

Cardiologists would be able to tell you down to the penny, the general physicians would not – they wouldn't know where to begin, and probably struggle to think who to ask other than a General Manager. What we've got here is quite behind the curve of understanding our costs, so I think we can understand the tariff, but what we're less good at and have put a lot of effort into this year to getting from zero to SLR and SLM(sp?), is actually understanding our costs at a specialty level let alone an HRG level.

And that's a bit of the old chestnut of apportioning fixed costs in the right way, etc.

Partly that, yes

So we've got some specialities at Consultant level understand tariff and have a pretty good idea…

We're getting there, but we haven't had very high engagement in consultants' involvement in the reference costs exercise, so hence that's a big area to look at.

So lets move on…

The one example I was going to give you is orthopaedics what we did do was get the reference costs exercise for orthopaedics and the tariff income – which is now three years ago, four years ago probably – and were surprised that it really broke even and we're probably the fourth or 5th biggest hip and knee replacement unit in the country so we kind of thought …making this back up. And so we did, on the back of that, look at well Theatres, prosthesis, and length of stay would be the three cost drivers and, is the easiest one, or relatively easiest one because it meant squeezing our supplier rather than making any fundamental changes so we did do a pretty intensive exercise which shook out maybe 20% off the prosthesis costs and actually from the surrounding Trusts on that deal and that was two current revenue years so that was directly driven by the fact that we thought we must be paying over the odds for the prosthesis because, OK we're middling theatre utilisation, we're OK so prosthesis just seemed right the area to look at and because we kept saying, we can't go on just this side of break even – because it was 2.5% reduction of share – it did actually get reasonable amount of engagement from reasonably astute financially individuals and that I think was a critical element so that was a very genuine example of us taking PBR tariff…

And did the Consultants…?

The Clinical Director understood within a second and a year's work to get the tendering and to get colleagues on line and to get them to reduce their range of prosthesis used, and there'd been some discussion for years and years so there was kind of an impetus to bring that forward.

Does PBR have an effect on the quality agenda? Clearly it has an effect on taking costs out of the agenda – what impact, if any, does it have on the quality agenda do you think?

At the moment it's either those where it's perverse incentives so quality in its widest sense is now … having spent 15 years telling people to reduce their follow-ups – it's a bit of money for old rope, so there's a bit of a disincentive on things like that – and one-stop clinics – there's no incentive to do those, telephone advice services currently there isn't. Currently we're trying to engage the PCT in saying, well look rather than us making some reverse decisions and brining those people back to clinic. In terms of where I hope it will go is in the length of stay agenda where it has definitely led us to looking at length of stays and at the moment we're looking at the fairly easier – relatively easier – areas of, for instance, day admission rather than brining them in one or two days before just to protect the bed. So we now have major projects who bring in a 'day of surgery' admission area so we get rid of the whole issue of pre-op bays, and that's partly driven by the length of stay issues and needing to drive those down where I hope it will go is areas like complications and medication areas and other things that will reduce it down.

And I suppose by looking at the pathway…

By looking and the pathway, by looking at the trim points – and again it's a bit of a perverse incentive excess bed days on length of stays which is where we're on £50 a day – we've lost £3m income three years in a row now by reducing length of stay and losing excess bed day.

Really

We've taken that on the chin because it's kind of the inevitable way things are going to go, it's got to be better for patients. We haven't quite reduced the bed base to reflect that reduction so…

Have you reduced the bed base at all?

By about 20 beds, so..

20 out of?

900, so it's only peanuts [do you want me to shut the blinds?]. So we're looking at length of stay going down partly it's just trends, partly is practice and partly it's we've been pushing this for years and years and we're not going to stop this juggernaut, but this really had a serious financial impact for us partly recycled into intermediate care and so on partly PCT but really there's got to be some shake out with the number of beds and secondly the quality agenda we're trying to show investments that deliver… that makes sense within PBR, sort of stacks up in that you massively reduce the stay you get the same tariff and you get a slight top up next year. It doesn't quite add up but it's beginning to get there – you've got a few things

you can chuck in to say that this helps to support the costs, but broadly there aren't that many ways that PBR currently supports clinical outcomes, probably one of the main argument we've got is that if you can win under PBR you can get surplus and if you get surplus you can invest in the things you want to do. So we've invested heavily over the next five years in capital, we're using that surplus and we're investing heavily in non-income generating areas this year so A & E, IT and outreach and others because it's a good thing to do and we can do it because we're financially sound,

OK. So you're saying PBR and the quality agenda, if anything, as we are now is creating disincentive on quality because it's perverse behaviour by the provider in some cases?

Yes, it doesn't encourage you to change , more on the patient satisfaction level – things like one stops, and [inaudible], and things like that.

Just as a side issue, as there been an indicator from the PCT that they're going to make the tariff more sophisticated by giving bonus for high performance on outcome?

No, I think if that's going to happen, it's going to happen nationally.

OK

Future PBR talked about quality indicators. I'm trying to engage the PCT in actually becoming a development site for PBR and trying to get them to generate some ideas but partly because of this dispute and partly because of the reorganisation they're only just now beginning to get on to what should have happened three years ago, so may be in a year or two's time that might start happening, but at this stage there's a very clear set of levers which is they basically beat us round the head if we're missing a target and that's how quality is driven rather than through the financial systems.

Terrific - you mentioned this variation in terms of clinical understanding of PBR and you mentioned it is by speciality [inaudible], is there anything in personal – I'm going to get personal about this – can you pick a trend up in the consultant body which are more engaged with an understanding of PBR or is there something that comes to mind?

Age isn't a particular characteristic I don't think, it's that financial astuteness – there are those that take to it naturally, there are those, particularly from private practice, that understand naturally more, there are those who want to develop a service and then kind of, not begrudgingly, but just want to understand 'how do I make the case' and there are a few of them who wouldn't naturally come to it but…

There's an understanding in this Trust is there, if you want to develop a service then prima facie its got to stack under PBR is that the case?

It's got to stack under PBR or it's got to be a really strong quality argument, and we have an annual 'bun fight' whereby these are the one that the Trust is investing in – they don't generate income, but we're investing in because they are the right thing to do, so there's a big investment in A & E with no income on the back of that but our patient satisfaction scores, our wait time are pretty much all the standard work – this was the, service in investments to try and bring that up so those are the two routes. It probably isn't quite so clear in the clinician mind that that's part of the …, but pretty much wherever they go there's going to be the message 'this ain't going to fly' unless we can make it stack up and there's a huge naiveté as to what income they can generate as in 'is the work there' you can make it stack up if you can do 1,000 extra endoscopies then yes you can generate the money to pay for extra consultants but, are there 1,000 extra to be done out there? Actually, it's not that sophisticated a question to say is the work out there? Where's it going to come from? So it's developing, but in terms of characteristics… the other one I was thinking about was whether the clinician worried that theirs was going to be the directorate that was under tariff… was losing money and what does that mean? And so a couple of examples, maternity was mentioned, gynae where the reference costs that they were losing money – well they crawled over it and tried to understand what was going on - and orthopaedics, so there are a few where they're driven to it because they're seen to be… you know they might manage on budget for years and years and years and therefore never been a problem and never appeared on the radar and suddenly they're losing money against tariff – well they've got to and I think there're been a fairly genuine engagement part of it's been understanding and being able to rubbish the figures because we can always rubbish reference costs. Part of it was understanding, well are there changes in practices, are there changes in coding, are there changes in things that will better represent what I do? So that I don't have to worry about whether… We've not ever yet seriously looked at this invest in any services, but they kind of know that that's not impossible and whilst that's a threat is probably more effective than any driver.

Than another driver

So then characteristics, it's more circumstance I think

That's very interesting, that figures with other stuff as well. Just before we leave the consultant body there's a couple of other issues I want to just look at. We're looking at PBR and the understanding of PBR and we mentioned the Clinical Directors. Who holds the budget – I presume you have the old triumvirate of the…

Yes, the Senior Nurse reports to the General Manager…

So it the duo?

Yes, the duo

Who signs off the money?

The organisation diagram says the General Manager is managed by the Clinical Director. In reality the Clinical Director will be sat next to the General Manager and be shot at if things are going awry so it very much is a shared… and that will vary on personalities as to who really understand the budget. I think both feel responsible, I don't think there's a Clinical Director or General Manager who don't feel responsible – there are degrees, but they're all responsible. Some will say it's circumstances, what can I do? But generally those are the two who will be the key.

If I've got your orthopods OK and we come in at the Director at £1.5m over budget and we haven't taken corrective action during the year through quarterly reviews and I'm sat there and I'm the General Manager with the Clinical Director sat next to me who's going to be the one who takes the can for the performance issue?

The General Managers will tend to have shorter total careers whereas the consultants will tend to have their whole working life although Clinical Director's on a three-year term and failure to engage in… if it's a significant variance, action's not been taken, then the situation will become intolerable, I guess, for the Clinical Director so their more likely to go back to a job in consultants – stage one, but then the General Manager is more likely to be looking for a new job which is probably more of a mind focusser than…

So the Clinical Manager physically signing off or…

Both will tend to but I think the General Manager up to £25k and the Clinical Director up to £50k but the vast bulk of them would be signed off by both…

OK, the actual budget at the start of the year?

That would be jointly negotiated again the General Manager doing the bulk of the work but the Clinical Director definitely being involved in the meetings.

Does he sign off on the…

Yes they both sign on the dotted line, this is the budget, this is the income target.

Useful, OK so they're both signing off, it's a joint responsibility; the Clinical Director has probably got a bigger safety net if anything goes wrong…

Yes, he's got the day job to go back to.

Absolutely

As far as I know I don't think any Clinical Director has been sacked as such, but it would tend to be the honourable thing…

Just talking about objectives for a second, the way this is going now is what we're trying to [inaudible], are there any incentives which are not aligned between General Managers and clinicians? That's what I'm trying to get at.

Clinicians in general or the Clinical Director?

I'm thinking particularly about consultants, because let be honest about it consultant

Managers are really the key to drivers. So thinking first about the consultant body what drives these guys?

It varies, the… in terms of them not being aligned… do you want me to answer that bit or do you want me to answer the general question about what drives them?

General question first about what drives them, then I'm going to ask exactly the same question about managers and then we can conclude by is there actually anything that is fundamentally out of line therefore?

OK, you kind of work on the basis that consultants will want to varying extents want to have a sold base in their NHS base as in quality, reasonable risk avoidance, they don't want to be all over the papers, whatever. So sit back having the base secure some will then want to go on to become clinically excellent recognised within the Trust, within the region, nationally etc. and that's either quality, publication or involved with national bodies and so on there's then

there's a competitive streak in just being better than others, which particularly surgeons seem to be more competitive than the physicians often – although not always. In the environment in which they work and how much they can improve the stats there are clearly those who want to go into management to shape the environment in which they work to drive things forward, etc. so it's the usual mix of security allowing you to be a bit more available or competitive or whatever you want or to build a service with a team to create the environment you want.

Do you think the building of the service is an important one for the majority?

Yes, most of them want to be part of a successful service. Most of them have their ambitions as to what they want to grow or specialise or whatever.

So they can then become… if I'm a cardiologist I'm interested in cardiology – not really what the orthopods,

Yes, yes,, by about 40% over the last 4 or 5 years whereas it used to be about 80 people who kind of knew each other and be a village and they were more generalists within their field you've now got 14 orthopds who are so sub-specialised they hardly talk to each other let alone the cardiologists.

Let's just talk about the managers then. Eight private practice, because you're in the South-East how significant is that?

Pretty significant, particularly orthopaedics, ophthalmology cardiology is quite large private practice.

Which are the ones who engage quite a lot in understanding PBR as well

Yes, yes.

So let's go to the managers then. You can talk about these, being one of them. Looking at your colleagues, particularly below Chief Executive – they're a breed unto themselves aren't they? What drives your colleagues do you reckon?

Here, in this particular Trust, there's quite a large group of long-serving General Managers which is actually quite unusual for a lot of Trusts where managers are only here for 2 or 3 years if you're lucky. We've got General Managers who've seen lots of different changes and

systems. So there's something about loyalty and continuity to the team as well as to the Trust and so on. So I think there's very much a strong streak running through which isn't represented in the other Trusts where I've worked, necessarily – or to such an extent. There's also a lot about not being at variance so as long as you're 'on target' or slightly above, then your're given the head room, you're not going to be pulled in front of the Headmaster every five minutes because you're overspent or because you're missing that target so there's very much a compliance with the targets culture and I think a lot of them get satisfaction out of seeing services develop – seeing there was a problem about a year ago and now we've solved it. Whilst that's not celebrated, that's probably the bits that keep you going on the hard bit. And then there's the social network of being in a community doing a public service that gives you that motivation that gets you through the dross and the hassle.

You didn't mention money once in that really because it's not a key…

No, no the General Managers are saying they should be re-banded so it's a factor. We don't have any performance related pay but we did use to have a system that was consolidated about 4 or 5 years ago – there's obviously a whole PhD in , pay and so on. No one gets in the organisation I don't think that's particularly dented our appetite for performing the issue is more around where we can align objectives if you've got PRP it's pretty clear everyone's earning the money and therefore everything must be bought at once. But I think everyone is reasonably clear that, you know, stay on the right side of income and expenditure, hit these targets and do the other stuff – the quality stuff. But I think as an organisation there's very much a sense that we're trying to get to the stage where we've got the head room to do the things we want to do

Do you think there is anything that you've not mentioned yet, or you have mentioned that you think are conflicting drivers or incentives between Consultants and General Managers?

Private Practice is a big factor and managing waiting times, waiting list initiative payments or worker going to private sector and there's increasingly Consultants setting up their own private chambers which they want to bid for work and we haven't quite got to that stage where there's an explicit conflict of interests, but there's had to be a lot of marking of territories and saying that is undeniably a conflict of interest – don't go there – so far it's not been brought to a head but we don't really want to be placed in a test case where the Trust can or cannot say that's a conflict of interests.

Can you give me a flavour of that?

The ophthalmologists, the radiologists, the anaesthetists at the moment all have their own private companies set up. They are set up to bid for work whether it's private or NHS whilst they don't have facilities currently then it's pretty limited what they can bid for but they could take work direct from GPs which would be income that would have been coming to the Trust so…

But that hasn't materialised yet?

It hasn't materialised yet, but the one area where it has – not from a company – but from Consultants operating en masse about £1.5m worth of work that's being going through the Nuffield private hospital for the last three years the Consultants get BUPA rate minus 20% but they're still getting 3 or 4 grand for a morning's work. We would only pay them £600 for a morning's work as overtime, if they did it within their core session they'd only be paid £100 or something, so it's pretty massive incentives to not manage waiting lists at base therefore the work has to be outsourced and the same guy's going it so very big conflict of interests there.

Do they declare that? As a purely governance point, how is that managed?

Well we know the cases that go to the Nuffield because we broadly send them there and within their job plans they're meant to identify the private sessions that they do, but beyond that…it's managed in the sense that as a Trust we recognise that this is necessary to meet the targets and that the Consultants effectively have some fair shares and if there seems to be blatant go slow on the day job then there'd be a pretty severe talking to but it's very much a gentleman's club.

OK, so Private Practice potential divergence of interests. What else do you think – is there anything else?

The clinical quality agenda versus 'we need to make it stack up' is potentially always there that kind of assumes Managers are only interested in money and they're not interested in quality and so on often it's the other way round, and often it's mixed so there's that, and probably also working practices in that if it's a convenient working practice for a consultant, it might not be best for the team or the patient or the system and how they use the theatres might be highly convenient to the consultants how they use the theatre time – might not be for the patient.

Yes, interesting – is there anything else you want to mention ? In your perception of say the last couple of years has quality been basically at a constant level or has it been declining?

Overall quality in a sense?

Yes

OK. I'd probably say it's been improving, partly moving to a more consultant led service partly the whole ….. led agenda, measurability, accountability. I think out time per clinic appointment is probably gone up, our degree of sub-specialisation has gone up markedly and these are all signs I take as being quite good indicators of quality. We haven't had swingeing, short notice slash and burn cuts so there has been continuity in service and, dare I say it, long term planning but reasonable forward planning I think, on service developments. Infection control has been increasing, although our rate of infection control has actually got worse this year, we've been consistently amongst the best in the country for MRSA and c. diff and so I think on a lot of indicators we're pretty…specialist nurses, and the softer side of particularly cancer care and others, I'd say pretty marked improvement.

What's been the driver for that then? Was it PBR, but we said not?

Probably the trend started way before PBR and we've probably more in spite of – been able to invest in some areas. I think it's more the clinical governance, the accountability, as well as broader trends in the Health Care Sector around , etc.

Has the Board had an impact on…?

It's difficult to say over the 20 months I've been going , the systems are established and the quality agenda clearly has an infrastructure – we actually, probably about 3 or 4 years ago, appointed quite a strong Clinical Governance Manager so whereas there's a lack of corporate processes prior, individuals like that setting up systems, a strong nurse and Clinical Director have meant that we have actually got the systems that we can measurably see that we are making progress. I think the Health Care Commission ratings are pretty hit and miss as to whether they're a good indicator of quality but in the absence of anything else they are a bench marking process and combined with the really detailed Audit Commission in depth studies of diagnostic services for instance last year means we are getting, I think, a better, more evidence based – and National Service Framework , is another driver and more evidence based comparable measures of quality. Where I think we've got a blind spot is the patient satisfaction aspect of quality,

OK, let's leave that like that, that's useful. We're just at the mopping up stage now. If we had a bunch of clinicians in this room now and a bunch of managers and what we're trying to do, is the Health Care Commissioner's coming and we want to show clinical and managerial engagement – that's our objective – and we have to set an agenda. What issues would you put on the agenda that would have those clinicians completely engaged with your managers?

So that both sides are as interested in it? I think some of the quality indicators we're developing I think around infection control and other areas where people can see that…I think

of the whole agenda, I can't see every clinician and every manager being as interested in every aspect, so I can probably only give you ones that would get the majority interested.

OK

And of those, I think it's probably around quality measures, Health Care Commission,

18 weeks, you know the measures whereby… of success because I think the vast majority of clinicians and probably all of the managers will see that we've got to get these ones right to be able to progress, so anything that's on the key point indicators you… we get a bit of kick back, but not significant kick back, it's just the target for target's sake. So while that's a fairly easy cop out most people do actually accept that, to meet the target than it is to mess it up. So I think reasonable engagement on that. What is interesting, and I don't know whether I've mentioned it, is that we're getting Quarterly Reviews with Directorates which would be… one interestingly several of the Clinical Directors want to bring Consultant, Senior Nurse and several other colleagues from within the Directorate to actually review the Directorate and speak up on behalf of it and the Exec Team and that agenda is interestingly being formed and we've got a sort of skeleton of performance indicators that we'll be using and those are – I'll just give you a – we're just working on that at the moment but it kind of gives a mix of quality indicators, finance, , performance indicators, patient survey type stuff, as well as the traditional things. So that's the beginning of where we're trying to get a data set which is more comprehensive of what's going on in the Directorate and where we can measure it of which we have really only discussed the exceptions.

Yes, OK, so that agenda is, hopefully working for the Directorates saying oh, the Execs are interested , would you say? So you're using that as a tool really to take the management agenda forward, with the clinicians?

Yes.

Interesting, is there anything else that you want to put on that agenda?

What for the Management, Consultants meeting?

Yes, say we had just the orthopods…

Yes – to get them interested – the service developments, the strategy where we're going as a Directorate which is the other part of the agenda for those meetings.

Yes

We've got things set out in here. How are you doing against the ones your Directorate has kind of got a lead on? Personally I'd also be pushing the patient centric agenda around – and there's a chapter on "putting patients first" which is around resolving some of the issues that don't necessarily bubble up anywhere else, but patients keep telling us 'why is our discharge a bit disjointed' , so there's a range of very clear areas where we're trying to progress making improved patient satisfaction.

So it sounds to me that it's about patients – patient focus. How patient focus can lead to the development of the speciality that's how you keep 'I'll be hitting the national targets and stuff' so they keep the nurses clear to do the development as well, so it's all quite linked is it?

Yes

OK that's interesting. Who is responsible for the quality agenda in the organisation?

Exactly, it is the Nurse Director. I will pick up aspects around the information and patient satisfaction and so on we're doing a customer care type programme and we've got to rename it, but something around that. So I'll tend to lead on the marketing, softer side, Belinda will lead on the governance side and the Medical Director will lead on a lot of the other aspects particularly NICE compliance, mortality as well as being very involved in the Risk Management Committee and governance and so on and appraisals but the define lead is Belinda.

OK, and who would you say runs with the quality agenda practically within the organisation if you had to kind of…?

Well we've got a head of governance and risk management so in terms of the more traditional risk management, manual handling, that agenda will sit with one of Belinda's deputies who's the head of governance risk management.

Does the Chief Exec have any act on…?

Yes, yes that's narrowed down to a few individual, I think you you'll see it's much, much wider. I think the Chief Exec's role will tend to be more around if there's an indicator going off or there's a strategic service development which is about, take a for instance, the Chief Exec is very involved with the redevelopment of our cancer unit where the physical facility is still very cramped and poor so he's has got very involved in championing redevelopment etc. so there will be lots of issues where there will be champions outside the traditional kind of…

And do you find that Managers will run… kind of support that?

Yea, yea,

Managers will run with kind of quality, or will it be clinicians who tend to run with quality issue and then the managers kind of pick it up?

Managers wouldn't tend to facilitate, they will be stronger at the systems and facilitation and so on, it would tend to be… the Consultants would tend to focus on the hard end of equality, the Managers will – and particularly nurses, Essex Care… Quality and Infection Control will tend to… and Education and so on…and Skills Development, will tend to lead on different aspects of quality – I can't quite understand why – the education aspect will tend to be nursing staff and the Medical side the Medical Staff so I think the Managers will tend to be more holding the ring and external influences will probably be a wider driver in that 'this must be done', or 'this standard must be met' rather than at this stage developing whole new concepts of quality as such.

On the money side, who tends to run with the money issues?

General Managers are ultimately going to be day to day making decisions as to levels of staff you can recruit and so on and writing the budget, so they all do the vast bulk of the keeping the budget.

OK, and at the Board level who tends to pick up the money?

The Director of Finance will report on it, in terms of the strategic decisions – it would tend to be the Finance Committee sees the business is roughly £50k or whatever or £100k so they will give detailed scrutiny therefore the Board probably isn't seeing anything other than the oversight and assurance of that process unless it's a big financial decision so for instance we have a lot of Board time debating buying the Derwent which was a private hospital site which the Board has now dedicated to a knee and hip replacement unit on the NHS. Lots of time spent going through that which was a whole Board decision because there were a lot of strategic implications as well as just 'does it add up financially?'

Did you borrow to buy it?

No we did that from our capital plan

So there was no borrowing, you just bought it cash on…?

Yes

Very nice too! Excellent. OK, just to turn to the Regulator. Has the Regulator – and I'm talking about Monitor, here, everyone does – Have they had any impact at all on the organisation in terms of productivity and efficiency arguments? ,

The setting of our criteria for your financial risk rating has had a profound impact on our budget strategy so in other words therefore we've gone out of this liquidity, so those matrix have definitely fed through so we can't afford that capital as well as our annual saving target which is going to rise to £5m the year after next so that's pretty worrisome as to how we're going to meet that before any tariff changes that are on top of that. So in that sense profound, although you wouldn't ask more than five people in the organisation to see that link, but it's there. Obviously the need to stay the right side has focussed the entire Board and other than that the organisation. What we haven't quite got across is the argument why you need a surplus and that is something we're working on as to how a surplus is not only nice, it's essential and that's probably driven harder by the Regulator's requirement than probably… I mean naturally NHS break even is fantastic you know the idea of having £2m or £5m slopping around at the end of the year seems a bit… goes against the grain. So that's a culture change we've not really got to yet. There's a huge embarrassment about declaring any surplus so it's very much an issue they don't discuss publicly, but if we do it's because we want to invest in next year's capital plan. Those are probably the two… and then of course there's the fear of being hauled up in front of the Monitor particularly the RNE(sp?) and Peterborough where you get the wrong side of the numbers and the message from the Nuffield's Trusts little case study for me I took away from that 'Um they thought the, came out 3-4% lighter on staff for the same activity", well we don't really want to go there if we can do that incrementally without going through the headlines to get there fine, well inevitable really, well you don't really want to do that in one year with a lot of pain and…

For you guys then Monitor has been a case of you've never had a harsh discussion with [inaudible], on the…

Yea,

…never had that harsh discussion but in the back ground it is an every present concern about making the system efficient to be able to deliver the projected services?

Yes

OK, Service Line Reporting, have they had an impact on you guys doing that, or is that just you guys 'we need to get there' what's your view on that?

They kind of said it was essential, they were pretty 'this is best practice, but you will do it' there was a pretty clear message that they would view it in a bad light if you didn't do it. So we've put the effort in – it's not perfect yet – but it's work improved, getting to Service Line Reporting. I think seeing Trusts that have done it that it is actually pretty sensible so I suppose it's a mix of it being logically the right thing to do and because naturally people want to ask questions 'that's my budget, that's my income, is that right, are we a profitable service?' And the clinicians who talk about 'are we making a profit?' And then the next question is 'Where is the profit going?' Fair enough, you know.

So monitor has had an impact but it's not one of those impacts that is so clear that when I look at Board minutes and stuff like that it will be omnipresent? You'll have your quarterly reporting…

I think it's one of the cultures, so it probably won't be in the minutes – minutes tend to be quite succinct and action orientated – but very much there's that everyone knows if we don't get this right, we're out so…

Concluding bits now. We've gone round the edges of efficiency, productivity etc. but no one's said what it is…

Yes we've got involved in cultural issues on the side …

What do you guys consider productivity to mean to this organisation – what does it mean?

Probably if you asked the majority of the general managers, clinicians, consultants etc, it's about staying in the black by whatever means – that means more productivity will take some costs out but that's what it means, you know, so probably as simple as that and not getting into huge theoretical arguments about what productivity is just staying in the black – and why it's quite difficult to move into surplus territory. To me I say it's around trying to understand – Service Line Reporting will hopefully inform that and again there's a growing pool of people probably in the organisation see this as at least knowing how we compare and we're miles away from by directorate kind of thing but it's got to come, you know. So I think that's the simple measures. If you then ask them, 'well how do you achieve that?' Interestingly this morning we had a financer saying, 'well for years we've always done a central cost improving programme where we've got the great and the good have come up with ideas and it's not been consistent so some Directorates will deliver huge and some will stay

very quiet. This year you guys say, you've got six months to come up with your plan to deliver 3% by directorate and that's quite a challenge, quite a kind of… and of course there are those who say 'we've over delivered, we've always been the guys who deliver on savings or credit awards or whatever, and now we're being forced to deliver 3%'. So without Service Line Reporting there's actually a strong argument to say, 'we're asking everyone to make a saving', which might be disproportionately difficult for some rather than others but this year we're going to ask the directorates to take the lead on that and the corporate centre will support. We're just cutting it a different way as they've asked probably three, four or five years it's been a central one. What we haven't squared off yet is the difference between cash releasing and productivity gain – we need to do a bit of both but we haven't quite set out what we want and that's partly about the uncertainty of the market.

So you haven't got to the position yet where you're doing your cost improvement programme you kind of say 'hold on, let's just dump the cost improvement programme – let's just sit back and say productivity is about holding input constant and getting greater output than we can charge for, or sometimes it's increasing inputs and getting greater out put – so you're not at that level where people are sitting back?.

No, I think what happens… traditionally yes it has been just take some costs out because on block contracts you'd ask for a bit bigger block and get the buggers to sweat a bit more! It would cover itself off, so you'd take some money out of the system and you've got some extra income from the block so you always had those, but it wasn't in your face explicit because there was a deal done with the SHA. We're now moving to a stage at a Directorate level we're going to have to make that decision at directorate level where I think I can do 100 more hips for next to nothing and that will contribute this…

So it can be, in your terms cash releasing either by not reducing costs, but by creating cash?

Oh sorry, cash releasing, I mean by reducing the inputs we actually take cash out of someone's budget. So deliver us 100 hips but at £98 instead of £100 so there's a bit of that which is, you know, bit of procurement, reduced head count so closing things, shutting things, whatever, reducing things and maintaining input but what we haven't really got into is explicitly saying 'for the same inputs, or a slight increase, we can proportionately increase the level of activity. We've kind of done it corporately as a Trust, but at directorate level or an HRG(sp) basis actually working out 'I can do that at a really low marginal rate'. So we haven't got into marginal rates much really, probably since resolving…

So when you've given the directorates the inevitable 3% you're probably really expecting therefore traditional cost improvement plan solutions rather than greater output?

I'd say we're probably going to do a bit of both I'm more confident that we'd see the cash if the cash is released and because of the uncertainties of the market you don't want to put all

your eggs into just growing your business to just increase your margins or to maintain your budget.

Right,

So we're kind of at that stage of not knowing whether we're going to have a PCT clamp down when the 18 weeks of over – you know, crash of activity, we don't want to buy secondary care thank you very much and therefore we're going to have to shrink; or whether we can just grow a bit, or grow strategically bits, that will generate the cash.

OK, so final productivity is in there and bottom-lining then, how much of a focus is productivity, for the organisation?

In some ways it's everything and in some ways it's nothing – I mean it's come up every day can we get this work through this list, sort of pressure and shove and push but in terms of a corporate process and handle and development work I think that's a big area where we need to grow our ability, our capacity to think and do that stuff. So I think the next six months will be interesting as Directorate is trying to struggle with this and corporately I'm trying to strengthen our business planning information function so that we can actually work with directors and say well if you do less of these and if you change that practice then its actually not driven by anecdote of whatever but actually some hard evidence that says the bench mark, should be two days less , as I say, that's beginning to happen so much as we hate it the NHS institutes productivity measures have started a debate and that led to lesser stay in pre-admission in surgery leading to what could be quite a major service change – and in cardiology where we've got a lot of patients sitting in beds waiting for a procedure so although the metrics are rubbish and how you can as a Trust save £5m on reducing pre-op bed days, we might save £200,000 and so there is some productivity metrics driving change.

If I was to say 'OK, I'm going to work for you Richard for six months' – you wouldn't want me as an employee by the way I'm crap – I'll come and work for you and we're going to find out what work productivity improvements are happening here – where would you send me?

To watch them happen, or…

To actually find evidence that they have happened ?

It would be interesting to look at Outpatients where there's been a very big focus on reduced DNA special clinic utilisation; I think that would be quite interesting. In terms of cardiology's use of their lab time and the work they are beginning to get into around the waiting in beds for a procedure that would be good, and also, although it's going back three or

four years looking at how they improved], catheter labs. That's reasonably well written up but that would be good – slightly dusty – but a good area to look at. I mean our procurement departments - in the widest sense, input costs has quite a lot of well evidenced better procurement practice. I think our HR management is mixed but a reasonably strong effort over several years on sickness management has reduced the inputs on that because there's some HR practice in some directorates isn't particularly good and some practice around length of stay reduction OK.

Where would you say particularly?

Particularly in surgery…

General surgery?

Yes, General surgery.

And, sorry I should say in orthopaedics where we've halved the stay at the new centre, and investment in OP physio. So as a case study the OP dedicated to epidemia would be really interesting because there's a whole load of practices which we knew made sense, but were really, really difficult to get change in practice, we moved into a new building and given some tight deadlines and expected measurements for moving into a swanky new building and in actual fact we've certainly seen the change in practice there is sill some debate about what is the most efficient use of theatres but that would be a good case study about putting dedicated, high volume, high value it's about 5% of the Trusts income, working to a dedicated facility. Does that take out the complexity of theatres which are set up to do anything from a toe nail to , bypass to cardiovascular surgery and the just cope with everything. Now that's great from the flexibility view but not necessarily

A final question. Is there anything that I haven't mentioned that you think is a driver for productivity?

Well, there is something you didn't mention which I'm surprised you didn't, which is the efficiency index or the…

Opportunity…

No the… when PBR came in the Trust was measured against the 100 as to its…

Cost index?

Yes, so we were 88 – I don't know whether that was… did you look at that in the 4 Trusts?

Yes

OK, I was just surprised that you didn't ask why you think we were 88

Well, I suppose all this is about what the drivers are to those kind of outcomes but…

88 was pre PBR

Indeed.

So we got to 88 without PBR so in many ways we've got this A1 surplus which we can't spend on quality and other things and we actually had quite a lot of internal tensions around 'well why can't we just spend it?' And a spend did happen last year on quality obviously it can never be big enough but… and the Trust that became FT, particularly the early ones were all the right side of the line because they got the transitional relief, so and for me, there's a particularly rich seam of work - I don't know who productive you know, it would be, to actually see its not just your costs and inputs but your measurement of your outputs that drove a lot of that so I think we're particularly fortunate in the way we're set up in having a relationship with Poole Hospital which a) meant specialisation services on each site rather than two trying to do everything and also a slight peculiarity of the PBR system meaning that work transferring between the two would generate a new tariff. So, if we were one Trust on two sites we would probably lose – I've no idea what the figure is but probably 2-3% - maybe not that much, but a significant chunk of income…

Interesting. Thank you very much

APPENDIX FOUR

EXAMPLE INTERVIEW RESPONSE SHEET

Interview Response Sheet……

…….

No	Main Question	Response
2	**Gentle Intro Question** Could you confirm how long you have been with the organisation, **your** current role and previous positions held within the Trust?	
3	Where would you say the organisation has focussed its main managerial energy since becoming an FT? For instance quality, design, efficiency?	
4	In the transition to FT did you perceive any change in focus? For instance, patient focus, governance	
5	How does the organisation measure its output (quantity and quality)?	
6	In your experience, do you think there has been any change in how outputs are measured in the last three years, and if so, how and why?	
7	In your opinion has the introduction of PbR had a material impact on costs, efficiency or quality within this organisation?	

No	Main Question	Response
8	What other main factors do you think have had an impact on costs, efficiency and quality within this period and how important where they relative to PbR?	
9	What is the level of clinical understanding, and engagement, with PbR.?	
10	Do clinicians have responsibility for delivering their service to a budget within this organisation? Has this changed over time?	
11	Which kind of personalities are most engaged with PbR within the organisation?	
12	How would you summarise the objectives of clinicians in this organisation? Has this changed over the last three years?	
13	What are the objectives of managers in this organisation? Has this changed over the last three years?	

No	Main Question	Response
14	What do you understand by quality of service?	
15	What has happened to clinical quality in the organisation in last three years?	
16	If a change in quality has occurred what do you think have been the drivers of that change?	
17	Who is responsible for the quality of care in this organisation? Has this changed over the last five years?	
18	Who is responsible for the efficient delivery of care in this organisation? Has this always been the case, if not what has changed?	
19	How engaged are managers in the agenda around quality of care in this organisation. Has this changed over the last five years? If yes, what is the driver of this change?	
20	Has the introduction of PbR had any impact upon clinical/managerial behaviour for instance cost, planning, and quality focus?	

No	Main Question	Response
21	On what issues do clinicians and managers engage most upon? Has this changed in the last three years?	
22	Do you consider regulators to have had any impact on the organisation, and if so, how?	
23	What does the organisation understand by productivity and does your view differ in any respect?	
24	To what extent is productivity a focus of the organisation? For instance, within the board, divisions and clinical teams?	
25	In which areas do you think productivity has increased most within the organisation and what has been the key to this success (if any)?	
26	Is there anything we have not discussed which has driven productivity in this organisation?	

APPENDIX FIVE

INTERVIEW GUIDE

No	Main Question	Prompts	Time Estimate (Mins)
1.	**Researcher Introduction:** -subject -process	Approx one hour Permission to record Outline objective	2
2.	**Intro Question** Could you confirm how long you have been with the organisation, **your** current role and previous positions held within the Trust?	Limit to last ten years Focus on experience breadth	1
3.	Where would you say the organisation has focussed its main managerial energy since becoming an FT? For instance quality, design, efficiency?	Service re-design Improving quality Improving efficiency	3
4.	In the transition to FT did you perceive any change in focus? For instance, patient focus, governance structures, cost control?	Patients Governance Cost control Board capacity Clinical Development	2
5.	How does the organisation measure its output (quantity and quality)?	Access Mortality Re-admission FCE/FFCE/Spells	2
6.	In your experience, do you think there has been any change in how outputs are measured in the last	Value added measures e.g. SF36/EuroQuol etc Improved data collection	

	three years, and if so, how and why?		3
7.	In your opinion has the introduction of PbR had a material impact on costs, efficiency or quality within this organisation?	Financial focus Focus on cost Focus on quality Long term service planning Proactive/reactive thinking Clinical pathway protocols	2
8.	What other main factors do you think have had an impact on costs, efficiency and quality within this period and how important where they relative to PbR?	National targets Regulators Financial position	2
9.	What is the level of clinical understanding, and engagement, with PbR.?	Conceptually understand Validate their cost data Coding issues Pathway review	2
10.	Do clinicians have responsibility for delivering their service to a budget within this organisation? Has this changed over time?	Do clinicians: budget set; know their service capacity; have input into SLA's; and accept responsibility for financial outcome of service.	3
11.	Which kind of personalities are most engaged with PbR within the organisation?	Age Specialty Training Experience	3

12.	How would you summarise the objectives of clinicians in this organisation? Has this changed over the last three years?	Personal technical development Career progression Clean hands Financial reward Social justice beliefs Status Health promotion Patient care	5
13.	What are the objectives of managers in this organisation? Has this changed over the last three years?	Career progression Clean hands Financial reward Social justice beliefs Status Health promotion Patient care	4
14.	What do you understand by quality of service?	Clinical process Clinical outcome General patient experience Timely access	2
15.	What has happened to clinical quality in the organisation in last three years?	Sufficient/insufficient data Improve/decrease Who reviews Clinician/managerial ownership	2
16.	If a change in quality has occurred what do you think have been the drivers of that change?	DoH Targets Regulatory Quasi-markets Clinician drive Managerial drive Cost control Productivity drives changing	3

		pathways Patient influence Commissioner quality targets	
17.	Who is responsible for the quality of care in this organisation? Has this changed over the last five years?	Medical Director CEO Board Everyone Difference between official/practice	2
18.	Who is responsible for the efficient delivery of care in this organisation? Has this always been the case, if not what has changed?	Exec Team Medical Director Everyone Finance Director	2
19.	How engaged are managers in the agenda around quality of care in this organisation. Has this changed over the last five years? If yes, what is the driver of this change?	Outcomes Patient Experience Measurement Value added Clinical influence Central direction	5
20.	Has the introduction of PbR had any impact upon clinical/managerial behaviour for instance cost, planning, and quality focus?	Understanding cost base Review of outlier services re tariff	3
21.	On what issues do clinicians and managers engage most upon? Has this changed in the last three years?	Organisational breaches of targets Service redesign Expansion plans Clinical quality Productivity and cost issues	2

22.	Do you consider regulators to have had any impact on the organisation, and if so, how?	Monitor Healthcare Commission Quality Cost control Data quality Clinician/managerial co-operation	5
23.	What does the organisation understand by productivity and does your view differ in any respect?	Costs Inputs (patient) Outputs Cost reduction versus productivity	2
24.	To what extent is productivity a focus of the organisation? For instance, within the board, divisions and clinical teams?	Work streams Clinical teams Divisional management Board Reporting systems	3
25.	In which areas do you think productivity has increased most within the organisation and what has been the key to this success (if any)?	A and E Orthopaedics Ophthalmology	1
26.	Is there anything we have not discussed which has driven productivity in this organisation?	People Other drivers	2
27.	**Closure** - appreciation		1

		Time Estimate	69mins